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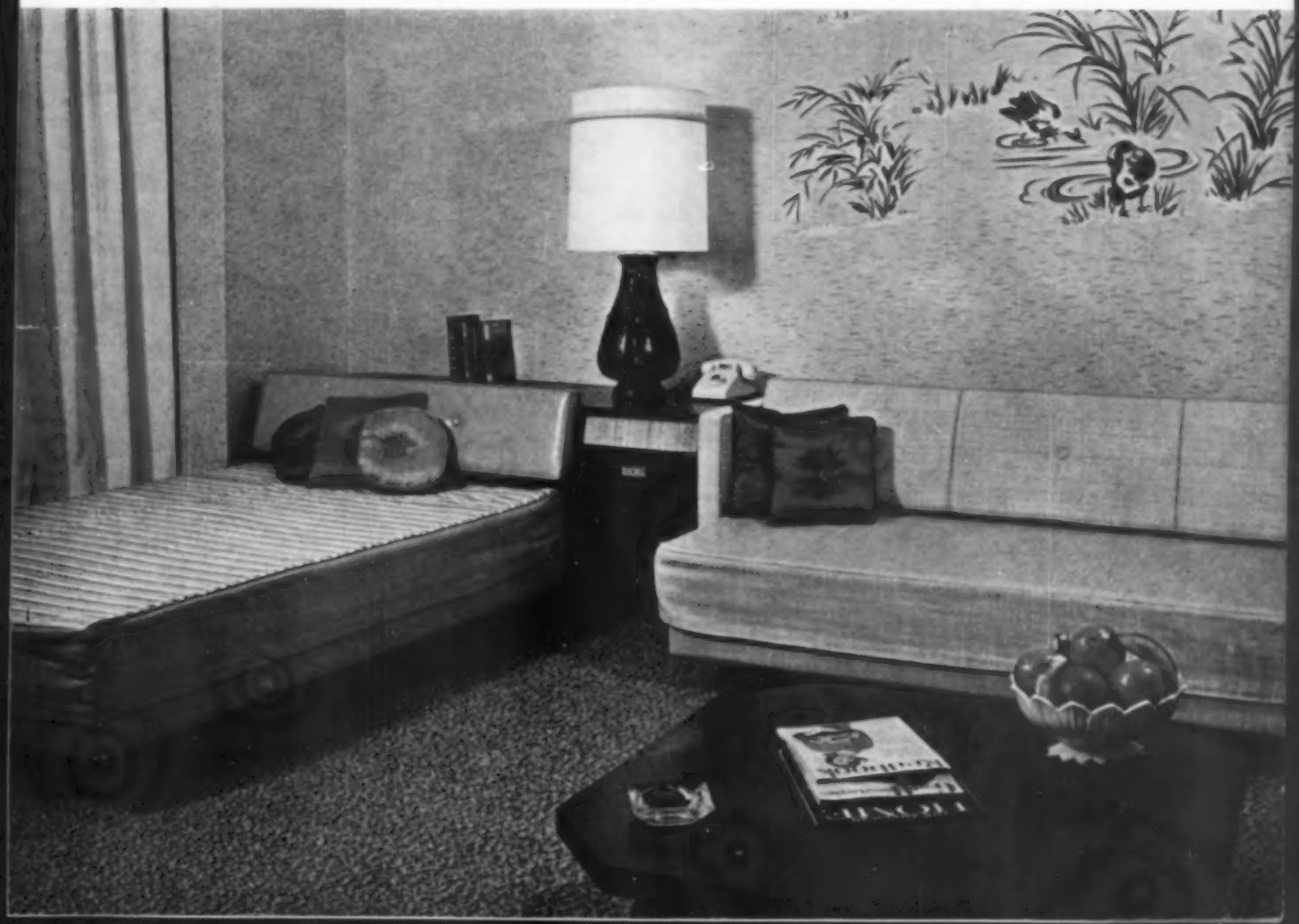
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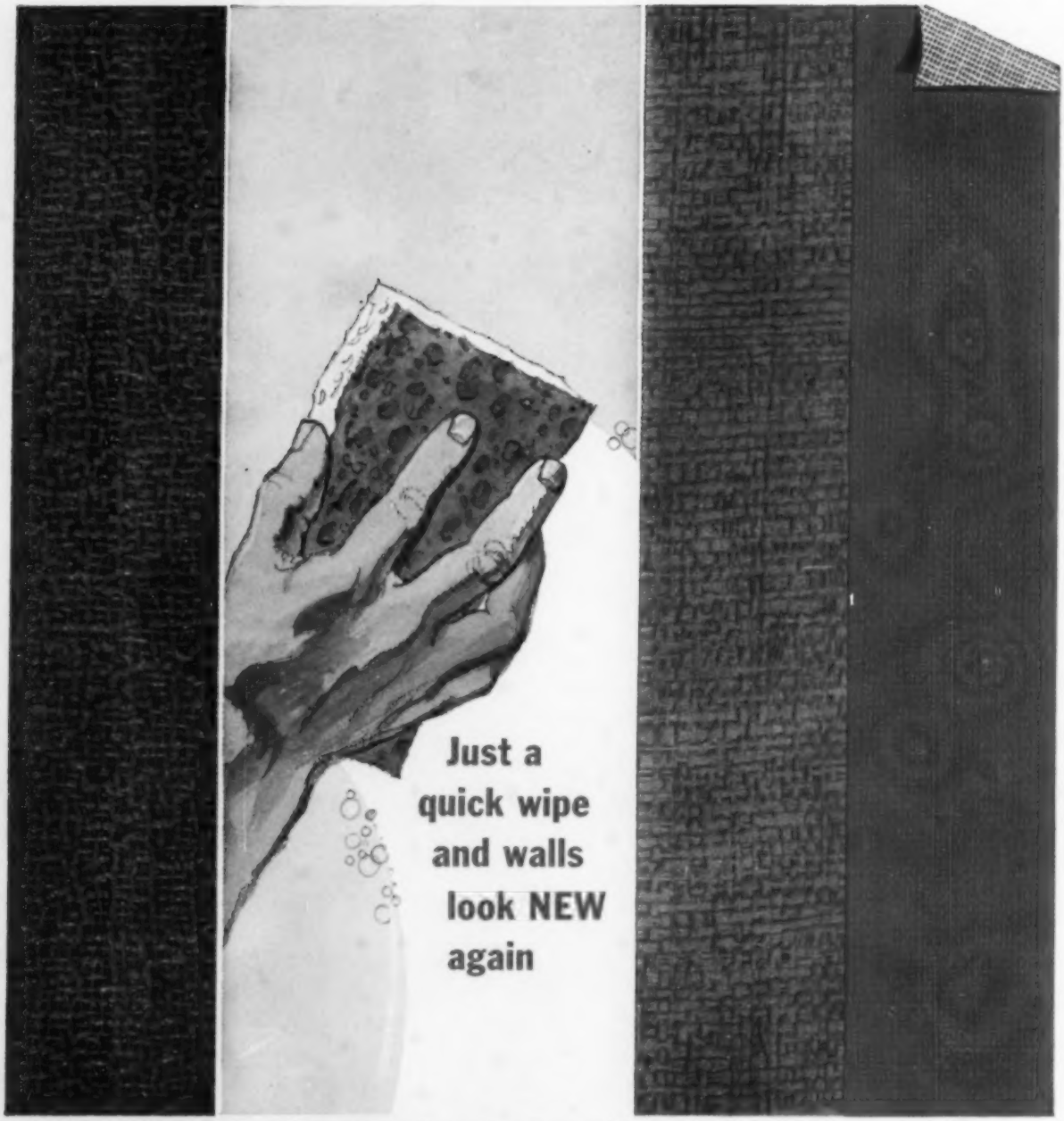
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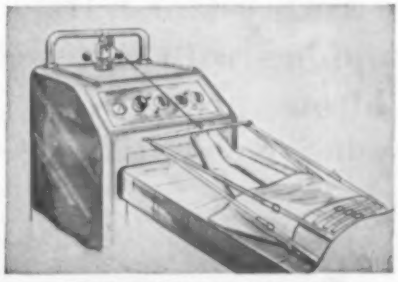
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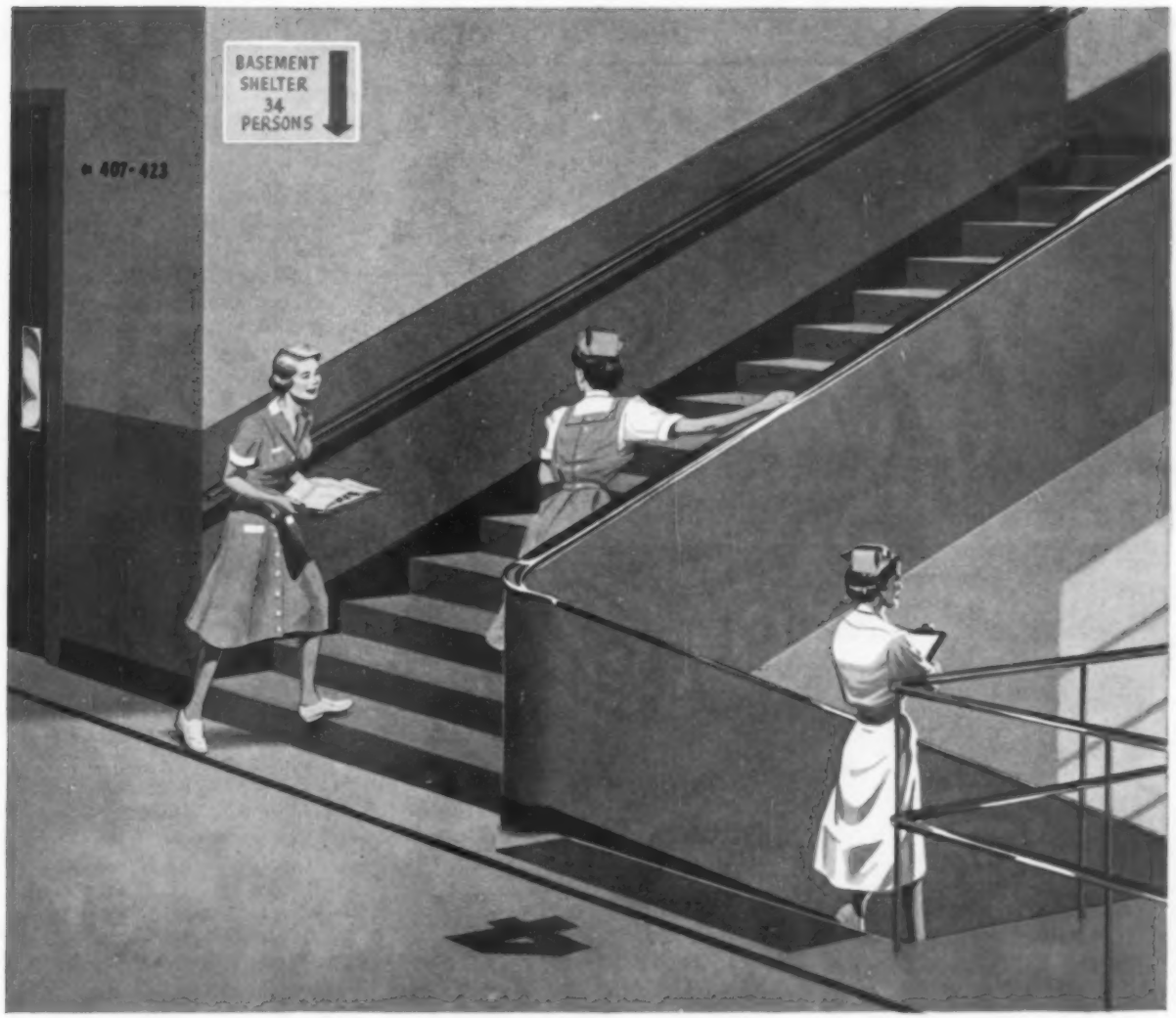
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READER OPINION

Why Must Articles Be Continued?

Sirs:

This is a spontaneous outburst following my perusal of The MODERN HOSPITAL for May 1961.

I can't for the life of me figure out why a person can't start and finish one article without switching from one end of a publication to another and without milling through reams of advertising. . . .

Now, persumably, you know your business better than I do. Certainly you know how to put a publication together and also presumably you must have advertising material to permit distributing it at the cost indicated.

As a reader of this and other magazines, I have about reached saturation point with this format.

Articles are in the publication to be read, and how to maintain a continuing line of thought as one hops, skips and jumps hither and yon is quite a complicated technic.

As I see it, the advertisements are there to be seen and have one's attention directed to their message. Consequently, one's mind and attention are diverted back and forth, forth and back, endlessly. I honestly believe one loses the value of both the very fine articles and the very fine advertising.

If you must intersperse the advertising, could you not put completed articles in – then a series of ads – more articles (completed, *not* continued on p. 101), then a series of ads, and so forth?

This holds true in the whole publication field. To me it is ridiculous, and I wonder someone hasn't risen in righteous indignation long since.

Surely we haven't degenerated into such stupid people that we have to be enticed into, through and out of a publication by such wiles as "continued on p. 101" to permit everyone to get one foot in the door.

I expect in all businesses we keep on doing things "because it has been done that way before." First thing we know we'll have half of two books in one volume and go back for the other two halves. It would be quite as sensible. My present technic is to read as I go and may I *please* find a clue as I pick up the latter end *as* I come to it and *when* I come to it, which might be days or weeks later.

Stella J. Sewell
Assistant Director
Surgical Services
Vancouver General Hospital
Vancouver, B.C.

The May issue, which provoked this comment, included three articles that were continued from one section to another. Our readership surveys indicate that some readers, like Miss Sewell, are annoyed by continued articles. But others want detailed information that can only be included in longer articles, sometimes necessitating these "jumps." We do try to keep the number of these down, eliminating the hops and skips, if not altogether the jumps.—ED.



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ROVING REPORTER

V.A. Hospitals Describe New Programs

What new or unique programs has your hospital inaugurated this past year?

This was one of 200 questions recently asked of the nation's Veterans Administration hospitals and clinics, in a questionnaire prepared by the committee on veterans' affairs of the U. S. House of Representatives. Every hospital and clinic responded and, although a few indicated no "new or unique" programs during 1960, most reported from two to four new activities at their respective hospitals.

The wide variety of the reports present an array of ideas and suggestions which might be of value to other hospital administrators who are interested either in improving current or in developing new programs.

Here is a selection of the ideas and accomplishments which have been grouped into five categories.

Management Improvement

- Established formalized goals for each service and division of the hospital.
- Initiated systematic management reporting system for department heads to top management.
- Established standards for production and performance in administrative and certain other departments of the hospital.
- Conducted methods and procedures study to improve functional services and production in central service and supply service.
- Established position of management analyst to study all management and service operations of the hospital.
- Established central linen supply and reduced supply issue points.
- Consolidated central service and operating room under one supervisor.
- Created budget control committee to consider all facets of operations and allocate funds on approved standards.
- Developed nursing procedure books.
- Organized nursing audit for nursing portion of patients' records similar to medical audit.
- Installed automation in fiscal and supply divisions.
- Consolidated all hospital memorandums of policy and directives into one indexed publication.
- Consolidated housekeeping and laundry activities under one supervisor as a pilot study.
- Converted difficult-to-maintain grassed areas to colored gravel.
- Instituted use of heavy plastic bags for disposal of garbage.
- Centralized salary and distribution center for personnel which includes credit union office, union desk, check cashing facilities, bulletin boards, employe newsletter, and other pertinent publications.
- Use of part-time labor for summer grounds maintenance during week ends.
- Appointed executive planning committee to assure broad participation in development of hospital programs and evaluation of their results.
- Coordinated a medical audit of all clinical folders including social service, psychology service, and nursing service. This resulted in better records, better care for the patients,



Consultations with leading pathologists throughout the country resulted in this functionally designed and structurally advanced autopsy table. All welded stainless steel construction with large radius inside corners, no lapped edges, rivets, bolts or other fastening devices facilitates thorough cleaning. The knee-operated, quick-opening waste valve and hydro-aspirator valve with automatic vacuum breaker are both designed for ease and convenience in operation. The Jewett Autopsy Table meets all the requirements of modern pathology.



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and an awareness on the part of the various disciplines of their particular performance.

- Inaugurated mobile centralized tray service.
- Transferred tray service duties from nursing personnel to dietetic personnel.
- Established a rehabilitation board.
- Opened new all-faiths chapel.
- Studied hospital infections control.
- Installed plastic wainscoting in corridors and selected patient care areas.
- Developed emergency radio network with other hospitals in the area to prepare for medical emergencies. Monthly exercises.
- Participated in interhospital conference with five neighboring hospitals for interchange of ideas and opinions.

Personnel Development

- Developed program for greater cost consciousness on part of employes.
- Utilized a patient-centered approach to teaching nursing assistants in the ward nursing area rather than in the classroom.
- Developed individual development plans for higher grade supervisors.
- Initiated planned career development program for employes.
- Initiated series of outside speakers for top supervisors to bring in new ideas for better patient care through better administration.
- Provided educational program for hospital professional personnel, utilizing talents of personnel from local colleges.
- Used middle management to formally attack work measurement studies.
- Studied contribution of nursing assistants and aides as key rehabilitation persons.
- Established an employe council.
- Established incentive awards committee.

Patient Services and Activities

- Recruited volunteers from among ex-patients.
- Social work service initiated patient placement and follow-up service in specialized and home care situations in a larger community about 75 miles away because it offered numerous resources for such placements.
- As part of patient orientation issued booklet, "Your Road to a Happier, Healthier Life," at no expense to government.
- Extended patient recreation activities to fill out evenings, week ends, and holidays.
- Made occupational therapy shop items enabling seriously handicapped to do many things for themselves.
- Developed a self-care program for older, long-term patients.
- Elected patient panels which make public appearances in the interest of community relations, public education, and volunteer recruitment.
- Coordinated managerial and professional services with a duly elected patient council representing the patients. Scheduled monthly meetings.
- Arranged for early action by social service to avoid delay in discharge for patients with identifiable socio-economic problems.

Community Participation

- Inaugurated annual career day for high school students.
- Inaugurated career orientation for college students.
- Increased participation of junior volunteers in hospital services.
- Developed employe-community relations committee.
- Scheduled and limited drug displays to one day a week.
- Scheduled regular group meetings with relatives of psychiatric patients for question and answer periods concerning their role in the rehabilitation of patients after discharge from the hospital and their return to the community.

Hospital Services

- Expanded home care program with special emphasis on training of patients and close relatives in technics of home care.
- Inaugurated own blood collection program.
- Established a progressive care program on neurology ward which includes an intensive care unit and special type dining room.

All of these approaches to improve hospitalization have not necessarily received formal endorsement of the Veterans Administration. However, the V.A. encourages its hospitals to improve services and to reduce costs wherever possible within prescribed policy. — WILLIS O. UNDERWOOD, *manager, Veterans Administration Hospital, Pittsburgh.*

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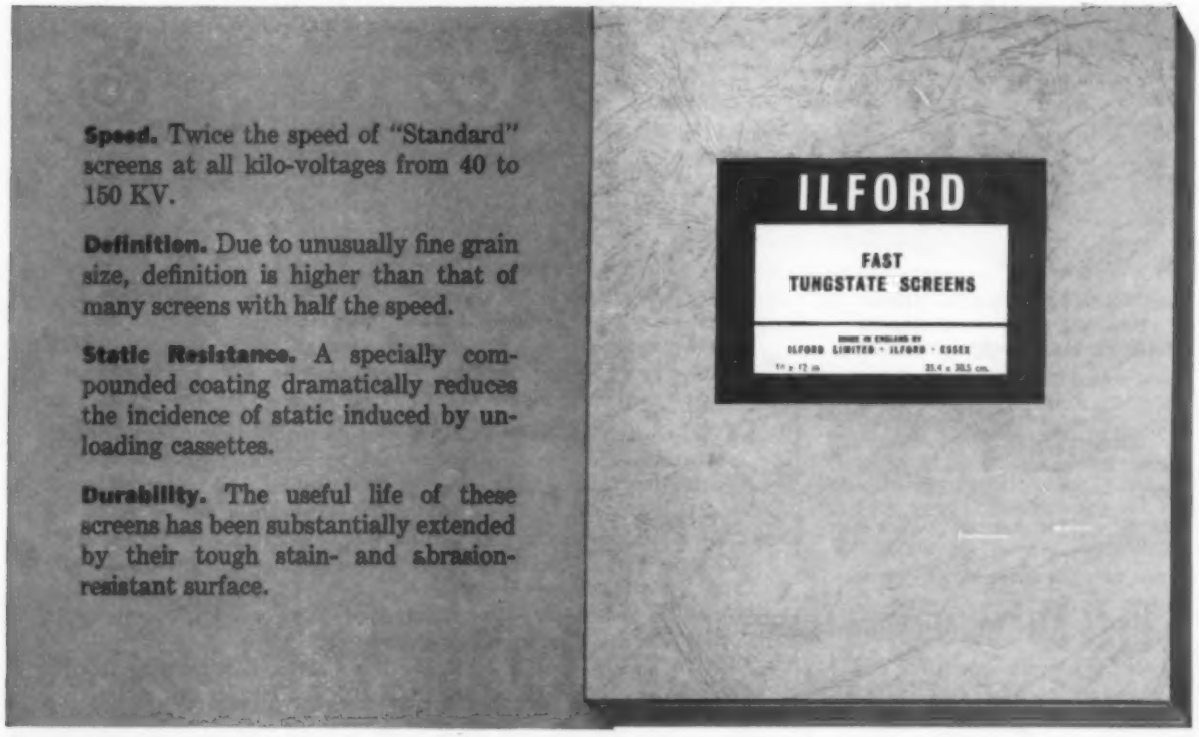
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Go the Limit on Hospital Issues When Seeking Support of Public

By Gordon Davis

IN PLANNING how to handle any public issue, someone has to make the decision whether to play it cool or play it hot.

The decision comes, as in all human affairs, from the strongest person on the scene — the leader, declared or otherwise. In a hospital, this can be the administrator, a trustee, a member of the medical staff, or, perchance, somebody's wife.

The current, perennial and practically universal drive to gain full-cost reimbursement from agencies of government calls for such a decision from hospitals collectively. What, indeed, is the best way to get state agencies to cough up?

Is it to play it cool, to consult calmly with agency chiefs and lawmakers, to point out the inequities of partial reimbursement, to supply facts and figures in laborious detail, to work patiently for a reasonable payment formula?

Or is it better to play it hot, to take it to the public, to blast the parsimonious politicos on the front pages if need be, recognizing the wisdom of the old saw about which axle gets the grease?

Hospital people are not politicians, thank heaven. They are inclined to shun street brawling, although there's no better device to arouse the attention of the neighborhood.

And it's even possible to find a lawmaker here and there who is so interested in human justice that he forgets about reelection, and because of this anomaly he gains equity without forcing the issue.

But the fact remains that the people, the ultimate bosses of the legislators, are not going to take the hospitals' side if they do not know that the hospitals have a side. In the matter of obtaining adequate reimbursement from government, and in most of the other issues they confront today, hospitals must have public support or they suffer diminution of their ability to serve the public.

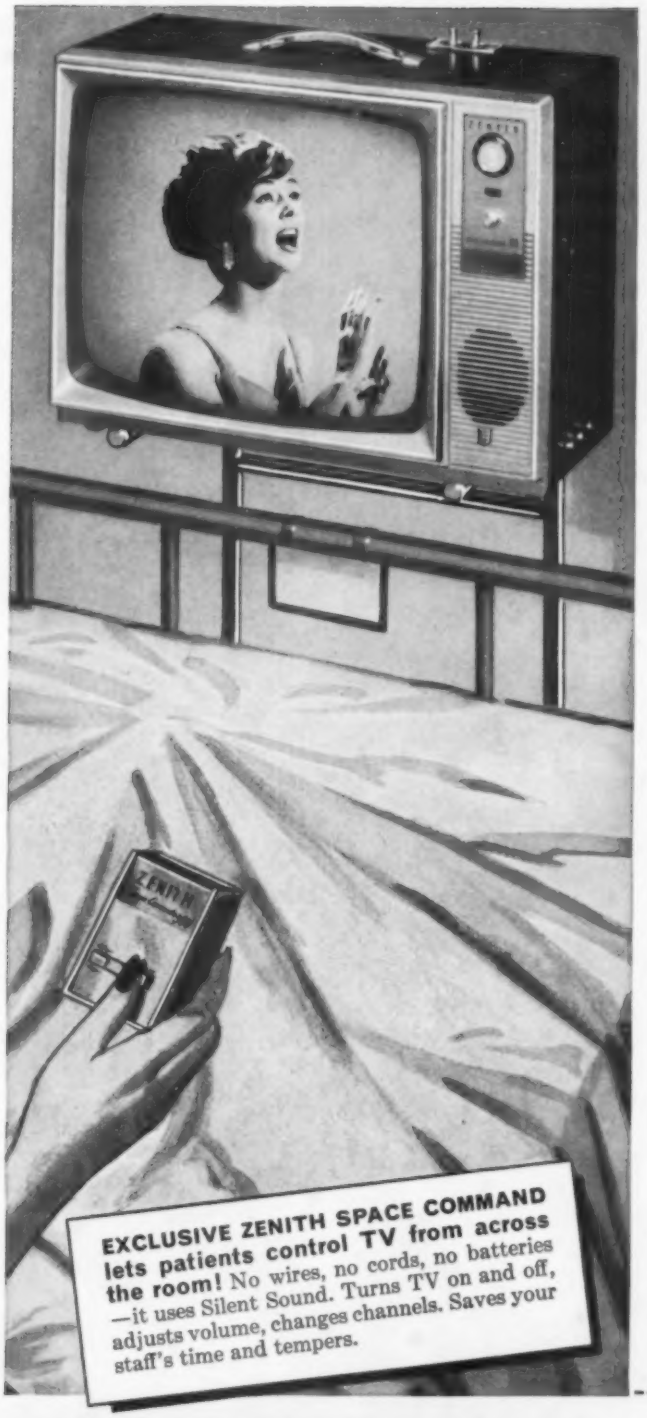
Observe carefully, as a potential parallel, the manner in which the present national administration is going about the business of achieving its objectives. In particular, notice the careful buildup of issues until the entire nation is panting over them.

There are some real pros on that public relations team! These people play it cool even when they're playing it hot. No attempt to avoid front page controversy. Quite the contrary. Controversy is used as an instrument of public education, to arouse sentiment, and put public pressure on the legislative branch.

Conversely, refusal to play it hot when the situation clearly calls for it is the course of certain failure. Consider this possibility in analyzing public apathy toward your hospital and its needs.

In the public relations sense and in terms of social progress, there really is no choice between fervor and frigidity. The game goes not to the dilettantes or to the cautious, but to those who play it with enthusiasm and determination. If you are truly dedicated to doing the best possible job of serving the people, you must be willing to go the limit to prove it.

This thought is one to chew on when or if you encounter a stone wall of indifference to your cause. ■



EXCLUSIVE ZENITH SPACE COMMAND lets patients control TV from across the room! No wires, no cords, no batteries—it uses Silent Sound. Turns TV on and off, adjusts volume, changes channels. Saves your staff's time and tempers.

ZENITH means greater operating dependability, fewer service problems!

Handcrafted Service Saver Chassis—no printed circuits, no production short-cuts! It's completely wired and soldered by hand, with top quality components throughout. This costlier construction gives you more dependable performance — cuts out-of-service time and costly repair bills!

New Gold Video Guard Tuner delivers a finer picture in any signal area! Fine-tunes each channel individually. New 16-carat gold-filled contact points assure peak signal power and long-life performance.

New High Speed Electron Gun "paints" more detail on the picture tube! Gives you a sharper, clearer picture. In a close-up, you can actually see the individual strands of a performer's hair!

Above, the Crestlake, Model H2214G, in metallic Ascot Gray color. Pillow and earphone speakers for private listening, and special roll-about stand, are available at extra cost.



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ZENITH RADIO CORPORATION, CHICAGO 39, ILLINOIS. IN CANADA: ZENITH RADIO CORPORATION OF CANADA, LTD., TORONTO, ONTARIO. The Royalty of television, stereophonic high fidelity instruments, phonographs, radios and hearing aids. 43 years of leadership in radionics exclusively.

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Chromic C
ST INCR

packaging choice for the packet of choice

STERILE-PACK DRY

At one time, suture packets were delivered to your hospital only in jars filled with sterilizing solution. This concept, first developed by ETHICON, was called STERILE-PACK.

Now, ETHICON offers you a NEW suture packaging choice—a STERILE-PACK system that delivers suture packets to you dry in a foil-plastic overwrap.

WET OR DRY—both of these systems are compatible with the way sutures are used in the operating room! For example, unused suture packets removed from the overwrap may be placed in ETHICON formaldehyde sterilizing solution, as is now the case, or unused suture packets may be returned to ETHICON for resterilizing and repackaging.

ETHICON thus gives you a choice... lets you choose the suture of choice, in the packet of choice, delivered to you in the STERILE-PACK system of your choice.

ETHICON®

Physicians in Iceland, too, specify PENTOTHAL



Red roofs, white ponies, and grey mountains are familiar features of Iceland. Familiar, too, in Icelandic hospitals is Pentothal. Here Pentothal's many advantages make it an anesthetic of choice—*Quick, smooth, delirium-free induction . . . moment to moment control of depth of narcosis . . . freedom from fire hazard . . . easy, uncomplicated recovery.* Your own hospital, too, can benefit from these same advantages. Talk to your Abbott representative and learn the details.

Over a quarter century of world-wide clinical experience backs your use of

PENTOTHAL® Sodium

(Thiopental Sodium, Abbott)

ABBOTT

ICELAND by Paul Sample.
For a wide-margin print, write
Abbott at North Chicago, Ill.





New
Improved
Design



Now Blood Handling is Easier

Like all good blood bags, Pliapak is compact, flexible, non-wettable, and virtually free of air embolism. But unlike older designs, Pliapak now offers these added values:

A 16-gauge thinwall needle gives the inside flow rate of a 15-gauge, but the easy venipuncture of a 16. An *extra-long collection set* (40 inches) provides more leeway for suspending, knotting, and cross-match sampling. *Imbedded protective hoods* offer easy access to the filled bag, with visual evidence that the outlets are sterile. *A roomy new label* gives you better space and organization for recording data.

Moreover, the Pliapak has now been built tougher and tighter, by use of heavier plastic walls. The tubing is changed, too, to a more flexible type; it makes white-tight knots easier to tie, and can also readily be sealed with dielectric or mechanical crimping.

Pliapaks are now supplied in convenient "flat packs"—four to the pack. They stack neatly, and take less space than ever. The pack consists of a triple laminated envelope: an outer layer of tough kraft, a center layer of aluminum foil, an inner layer of polyethylene film. Inside, each of the four Pliapaks is individually sealed in its own polyethylene pouch. Unused Pliapaks may be held in these sealed inner pouches for 40 days after the outer envelope has been opened.

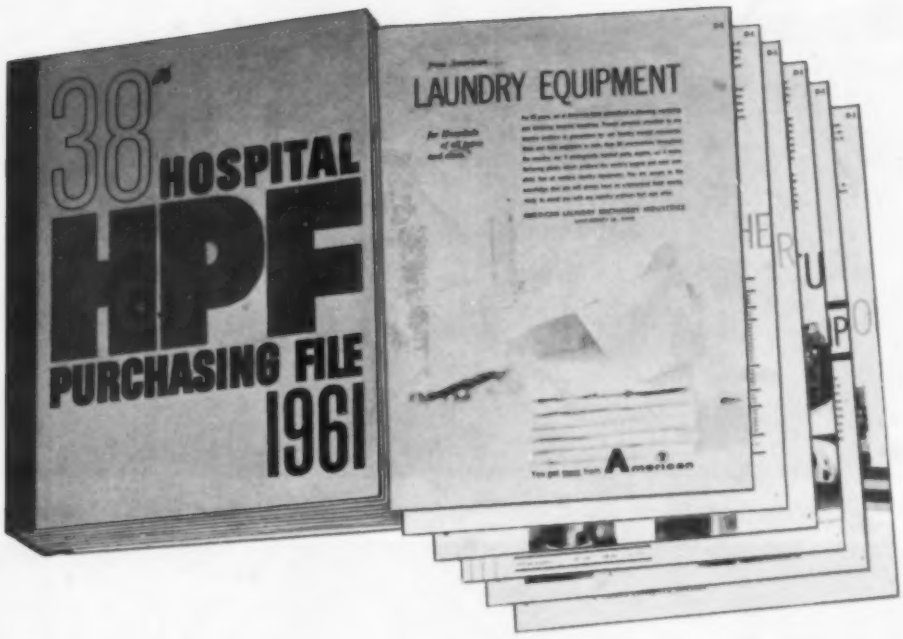
Would you like a demonstration? Contact your Abbott man, or write us at North Chicago, Illinois.

PLIAPAK®

A-C-D SOLUTION IN 500-ML. AND 250-ML. SIZES




PAUL SAMPLE



the hospital laundry

Probably the most complete catalog of hospital laundry equipment in your office is the 12-page catalog of American Laundry Machinery Industries in the copy of HOSPITAL PURCHASING FILE which is, or should be, right on your desk. American's catalog, Number D-1, shows an extensive line of washers, extractors, tumblers, finishing equipment and controls, with essential information on dimensions, required floor space, and capacity. . . You can plan a laundry or any other hospital department, or find illustrations and descriptions of nearly everything needed to equip and stock a hospital — right in the pages of HOSPITAL PURCHASING FILE, where suppliers most eager to serve you have filed catalog information. You'll save time and money by reaching first for your copy of HOSPITAL PURCHASING FILE, and by being sure that your department heads know where it is and how to use it.

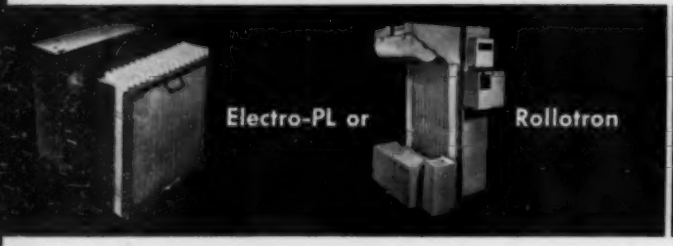




corridors, administrative offices . . .



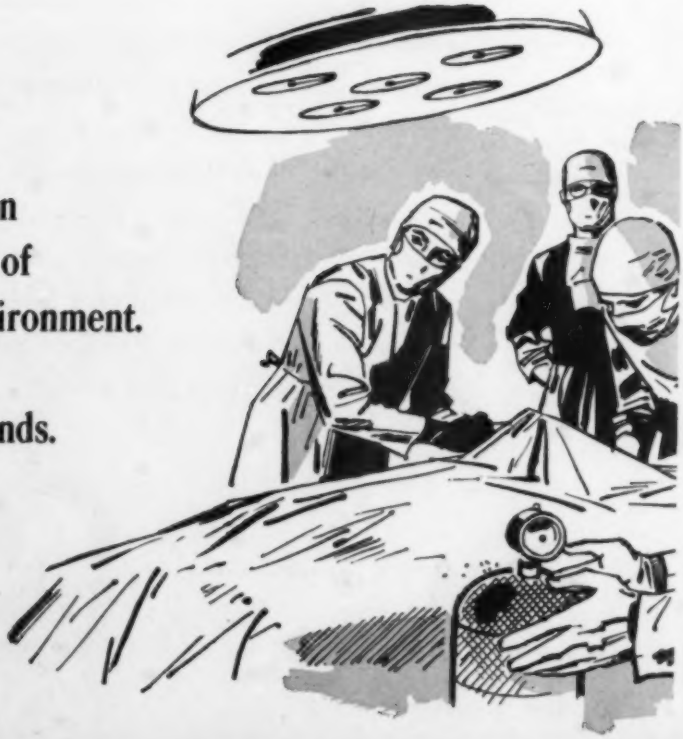
kitchen (supply & exhaust) . . .





For every hospital clean-air need

No one type of filter can meet the varying needs of the modern hospital environment. That's why AAF—and only AAF—makes all kinds.

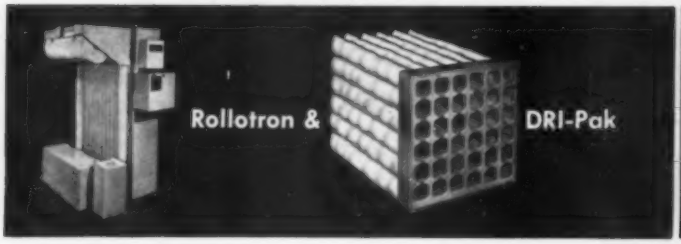




surgery, nurseries, labs . . .



laundry (supply & exhaust) . . .





there's an AAF product to do the job!



Unless you consider *all kinds* of air filters for every hospital need, you can't be sure of getting optimum correlation of filter performance, filter cost and filter maintenance.

You can *consider* all kinds *only* by talking with the company that *makes* all kinds. That company is AAF, whose filters are keeping air clean in more than a thousand hospitals from coast to coast. AAF dust collectors, too, are being used extensively for such operations as lint collection, glove dusting, and incinerator exhaust.

Let us show you how our complete-line approach assures you of the *right* filter for each hospital need. Booklet 249-P3 gives details. For your free copy, call your local American Air Filter representative or write us direct. Address: Robert Moore, American Air Filter Company, Inc., 486 Central Avenue, Louisville, Kentucky.

AAF **American Air Filter**

BETTER AIR IS OUR BUSINESS

See the AAF exhibit at American Hospital Assn. Show

How *Imaginative Engineering* Put Taming Chicago's



John Dolio (right) in front of Powers Graph-O-Matic Control Panel with E. S. Anderson, engineer for the Illinois Psychiatric Institute.

The unusual temperature requirements specified for the new Illinois Psychiatric Institute presented an extraordinary challenge for John Dolio & Associates. This Chicago engineering firm was asked to provide an absolutely uniform temperature throughout the 11-story, T-shaped building. Because temperature variations cause extreme discomfort —even pain—to mental patients, the system had to be accurate, foolproof and automatic. Because Chicago temperatures rise or fall to extremes within hours—sometimes minutes —the system had to be capable of sensing the changing weather picture outside and automatically and simultaneously reacting inside.

The resulting design provides all the answers . . . in a Powers pneumatic control system that operates automatically 24 hours a day—every day—at a bare minimum of cost; a system that compensates instantly for sudden outdoor temperature changes; a system that can be checked and controlled by one man.

The result is a functional system of control where practical engineering principles were combined by the Dolio firm with a strong helping of ingenuity in order to whip some of the more unusual problems. For example, since chilled water was to circulate through ceiling heating-cooling panels, a safeguard against condensation was necessary. The engineers solved this problem with a series of dew point controls mounted at various locations in the ceilings. Thus, "controls on a control" prevent water temperature from falling to the point at which condensation could occur.



Phil Derrig, Chief Mechanical Engineer of the Dolio firm, inspects one of the dew point controls specially designed to prevent condensation of cold water in the ceiling heating-cooling panels.

Powers Temperature Control To Work Weather At Illinois Psychiatric Institute

Illinois Psychiatric Institute
Chicago, Ill.

Illinois Supervising Architect:
Louis H. Gerding

Architects:
Shaw, Metz & Associates, Chicago

Associate Architects and Engineers:
Fugard, Burt, Wilkinson and Orth

Consulting Engineers:
John Dallo & Associates, Chicago

Heating, Air Conditioning Contractor:
Gallaher and Speck, Inc., Chicago

Ventilation: Zack Co., Chicago



JOB DETAILS

The system encompasses 12 temperature zones, each designed to operate independently in relation to individual zone exposure problems. Ten zones utilize ceiling heating and cooling panels at which hot and chilled water circulate from zone exchangers. Three-way control valves for the water are modulated by pneumatic thermostats in various rooms. Two zones — auditorium and stairwell — have only heat exchangers (the auditorium is supplied with individual conditioned air).

Master outdoor controls sense the changes in temperature outdoors and instantly reset submaster pneumatic thermostats at the zone exchangers. These indoor-outdoor controls are engineered for foolproof maintenance of uniform zone temperatures.

A central control board, the heart of the Dallo design, monitors the complete heating, cooling and ventilating system. The building engineer alone can instantly check 170 control points by merely referring to the Powers Graph-O-Matic Control Panel.

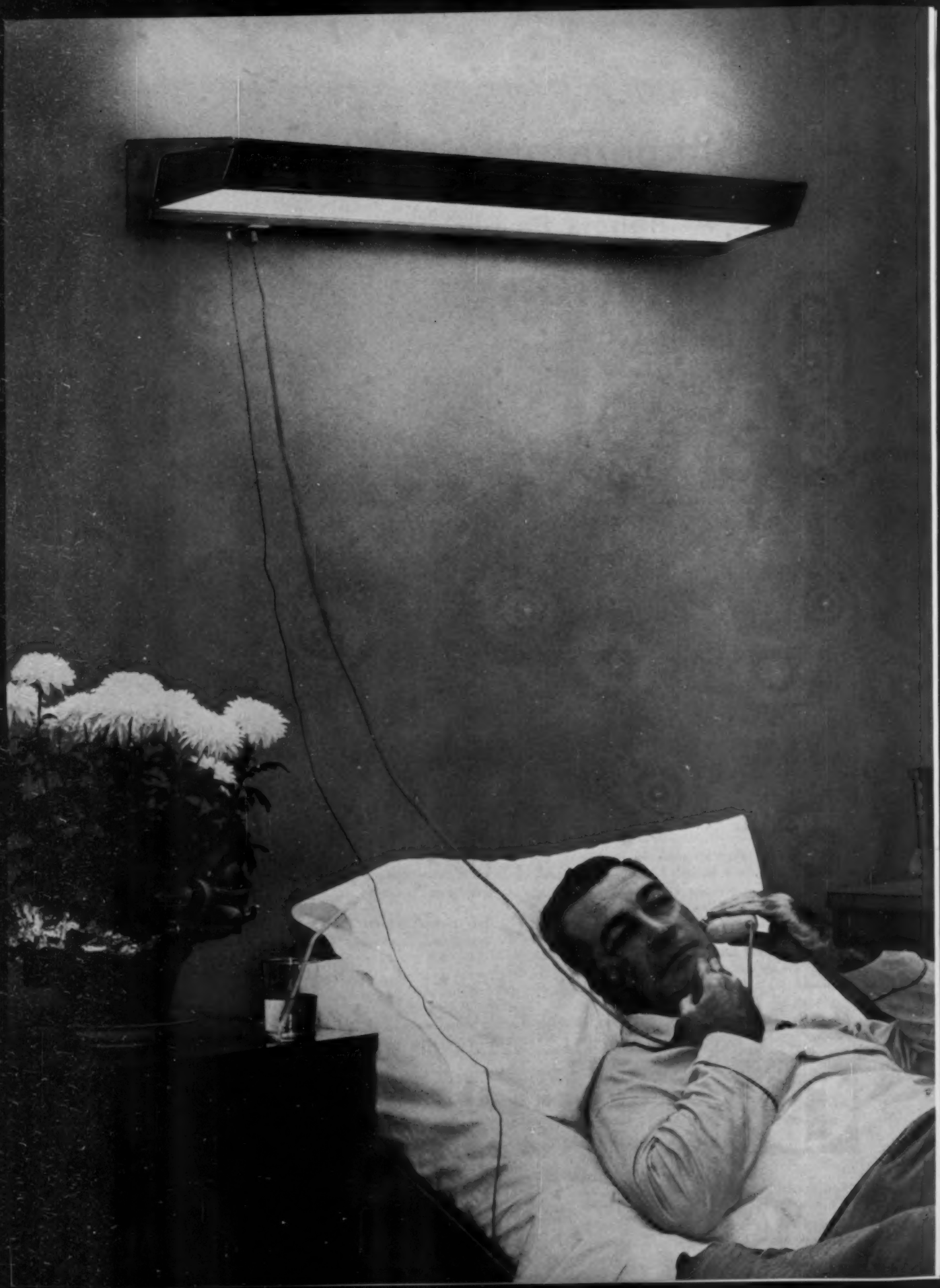
Temperature controls are inaccessible to patients. All controls in the corridors are wall-mounted and cabinet-enclosed; temperature sensors are mounted in ceiling exhaust ducts.

Easy servicing and low maintenance are two big reasons why a pneumatic system of control was specified by this engineering firm. Efficiency at low cost is characteristic of this type of control — as it is with the Powers pneumatic system installed here.

Safety and comfort for patients is provided for throughout. For example, in hydrotherapy, in showers, in sitz baths, etc., Powers Hydroguard® thermostatic water controls prevent scalding and eliminate dangerous water temperature fluctuations.

Write for the latest Powers Hospital Catalog.
Write us also for catalog on time-saving, money-saving pneumatic tube systems manufactured by our new subsidiary, the Grover Company.

THE POWERS REGULATOR COMPANY
DEPT. 961, — SKOKIE 57, ILLINOIS | *Offices in Principal Cities in U.S.A. and Canada*
MANUFACTURERS OF CONTROL SYSTEMS SINCE 1891





Patients look better, feel better and see "Decidedly Better" with

TRANQUILITE

NEW HOSPITAL BED LIGHT BY DAY-BRITE

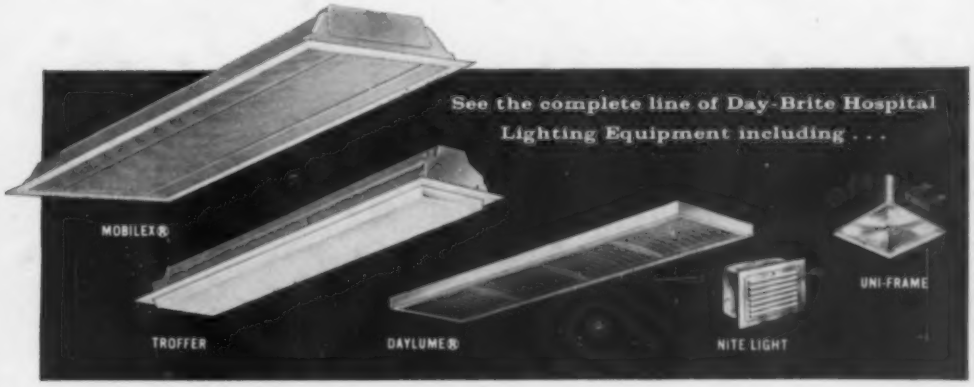
What a difference TRANQUILITE makes! New hospital rooms become less clinical looking, more inviting. In older rooms, defects seem to disappear under TRANQUILITE's soft illumination.

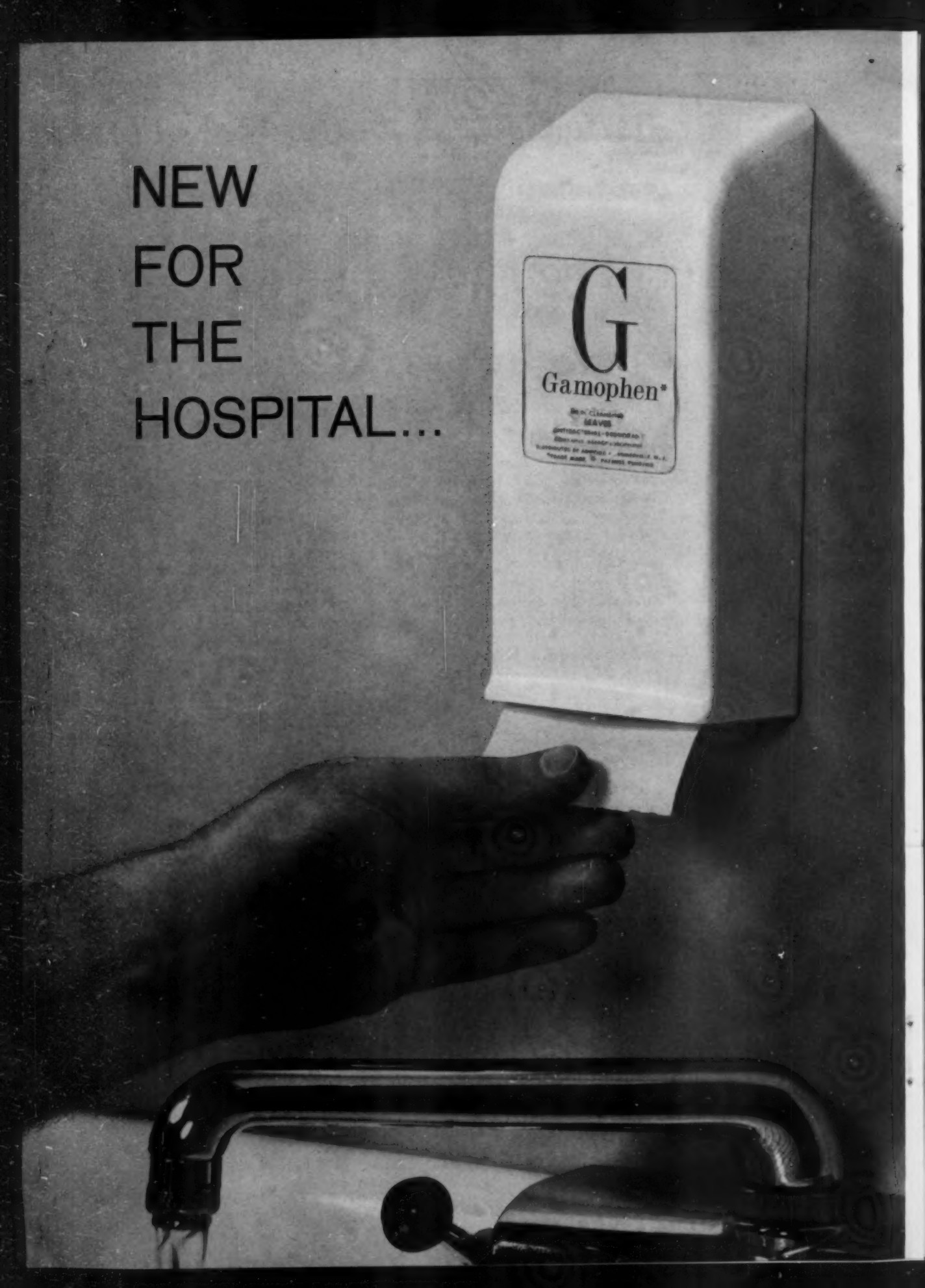
Cleartex® type panels reduce glare, making TRANQUILITE ideal for multiple-patient rooms. Switching provides general illumination, reading light and night light. A handy outlet is provided for examining lights, electric razor or radio.

TRANQUILITE is available in 2- or 4-foot lengths, in stainless steel or baked white enamel finish. For additional information, contact your Day-Brite representative, or write: **Day-Brite Lighting, Inc., 6260 N. Broadway, St. Louis 15, Mo., and Santa Clara, Calif. In Canada: Amalgamated Electric Corp., Ltd., Toronto 6, Ont.**

DAY-BRITE®

NATION'S LARGEST MANUFACTURER OF COMMERCIAL AND INDUSTRIAL LIGHTING EQUIPMENT




NEW
FOR
THE
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G
Gamophen*



Gamophen®

SKIN CLEANSING LEAVES

HELP PREVENT CROSS-CONTAMINATION

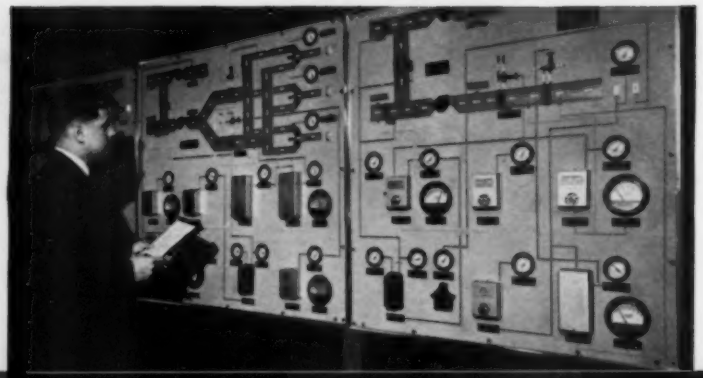
You touch nothing but the soap you use ...and only **you** use the soap you touch. Attractive wall unit dispenses individual leaf of surgical cleanser that dissolves completely...lathers richly...cleans hands without detergent irritation...assures prolonged antibacterial protection. Ideal for nursery, examining rooms, washrooms, nursing stations. For free sample, write to:

ARWOOD

Somerville, New Jersey

AVAILABLE THROUGH YOUR SURGICAL SUPPLY DEALER

Behind the scenes, Johnson graphic panels simplify the supervision and control of air conditioning equipment. Temperatures in administrative areas and doctors' offices are individually controlled by the occupants.



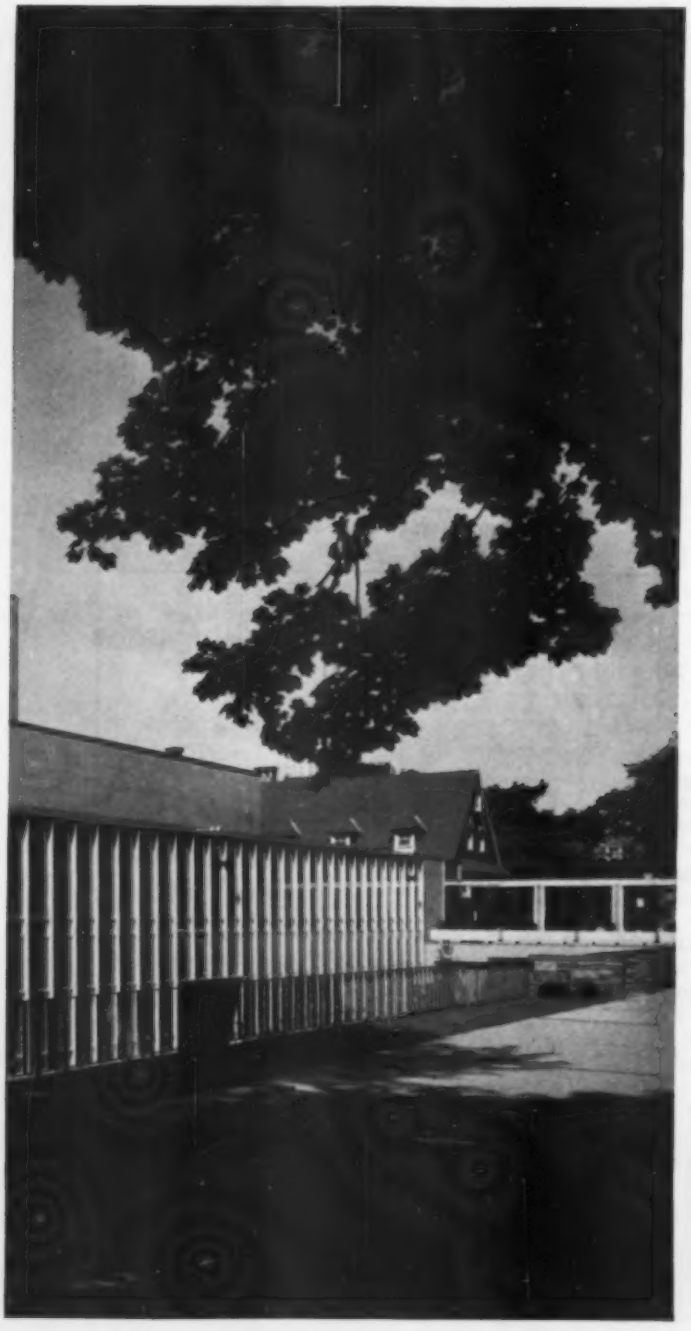
The Occupational Therapy Building includes a gymnasium-auditorium, model kitchen, workshop, library, snack bar, and beauty shop. It is rated among the best in the nation.





Typical lounge area.

North Building, Pennsylvania Hospital, Philadelphia. Martin, Stewart & Noble, architects; Robert Allan Class, associate architect; A. E. D'Ambly, mechanical engineer; Stofflet & Tillotson Corp., general contractor; Williard, Inc., mechanical contractor; all of Philadelphia.



controlled environment aids in mental care

Planned and equipped to utilize the latest concepts in psychiatric care, the new North Building of Pennsylvania Hospital, Philadelphia, is one of the outstanding institutions in its field. Actually, North "Building" consists of two buildings — the 5-story Patients' Building and the Occupational Therapy Building.

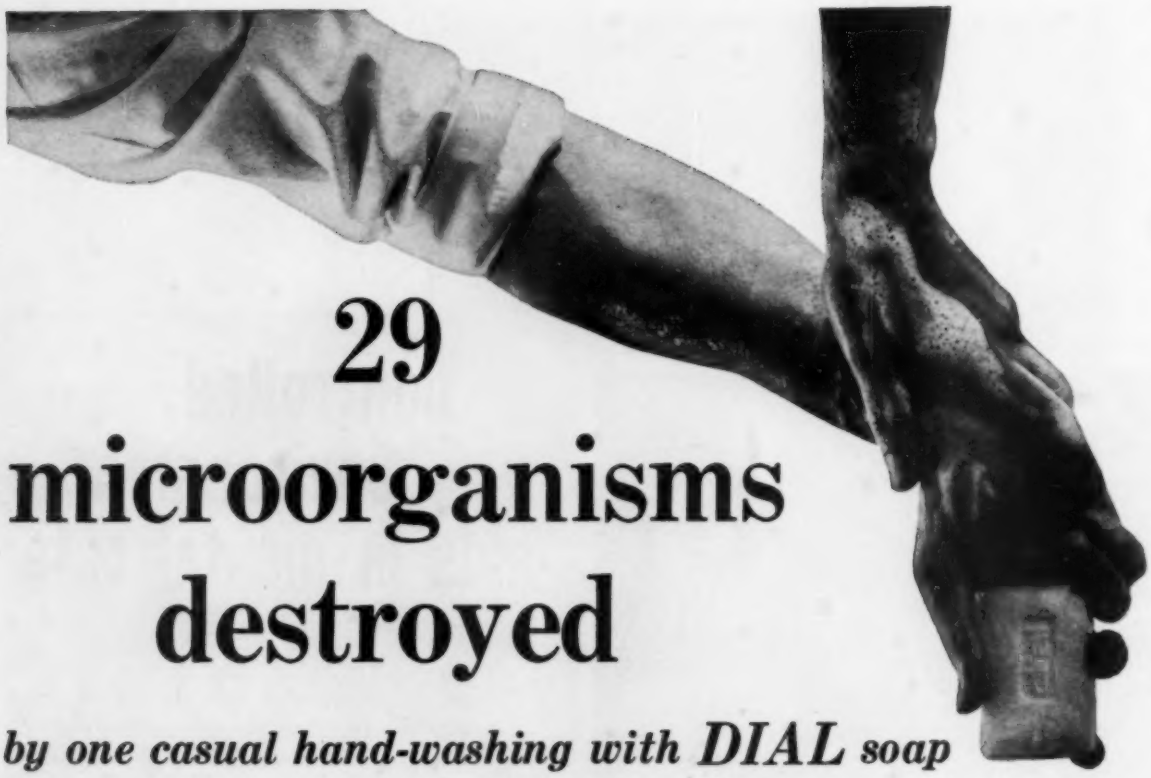
From floor plans to color schemes, furnishings, and equipment, each of these buildings provides a carefully controlled physical environment for the patients and staff. Both are fully air conditioned and equipped with specially planned Johnson Pneumatic Control Systems. Engineered for economy as well as for comfort, Johnson Control maintains ideal air conditions for every purpose with a minimum of time and attention.

Leading hospitals everywhere depend on the efficient, trouble-free performance of Johnson Control. When you build or air condition, talk to your architect, consulting engineer, or Johnson representative about the superior operating features and low lifetime costs of a Johnson System. Johnson Service Company, Milwaukee 1, Wis. 110 Direct Branch Offices.

JOHNSON CONTROL

PNEUMATIC SYSTEMS

DESIGN • MANUFACTURE • INSTALLATION • SINCE 1885



29 microorganisms destroyed

by one casual hand-washing with DIAL soap

Routine use of Dial by patients and personnel suggested as an aid in eliminating one source of infection

New and more extensive tests have established that Dial soap destroys a wider range of gram-positive and gram-negative microorganisms, and controls their growth, than any other bar soap designed for hospital use. Latest tests show that Dial is effective against 29 strains with a casual hand-washing. These organisms include *six strains of Staph aureus*, along with others which resist antibiotics.

The antibacterial ingredient in Dial—a synergistic combination of hexachlorophene and trichlorocarbanilide has long been known for its effectiveness against skin bacteria that cause perspiration odor. Dial's antibacterial properties have been familiar to physicians for a considerable time. And now, this new evidence sharply points up the benefits of Dial for routine use by hospitalized patients and hospital personnel.

With its unique antibacterial benefit you might expect to pay extra for Dial—but you don't. You can trim costs even more by choosing the bar sizes suited to your hospital needs. Three hospital-tested sizes are available—1, 1¾ and 2½ oz.—also others. Write our laboratory at address below for technical and clinical information.

Antibacterial spectrum of Dial soap

Soap Concentration For Total Kill, ppm* Microorganism	Dial
1. S. aureus (No. 209) **	10
2. S. aureus 388010 ***	10
3. S. aureus 388014 ***	25
4. S. aureus 388062 ***	25
5. S. aureus 388115 ***	10
6. S. aureus 388128 ***	10
7. S. lutea	3
8. E. coli	5000
9. S. oranienburg	4000
10. S. typhosa	9000
11. S. pullorum	4000
12. P. mirabilis	6000
13. P. vulgaris	8000
14. S. marcascans	4000
15. S. flexneri	5000
16. P. fluorescens	9000
17. B. cereus	10
18. B. megaterium	10
19. B. s. v. niger	25
20. B. s. v. atterimus	10
21. B. ammoniagenes	10
22. S. faecalis	25
23. M. phlei	10
24. M. smegmatis	10
25. N. catarrhalis	10
26. C. albicans	4000
27. S. cerevisiae	4000
28. T. interdigitale	50
29. Airborne mold	1000

*Soap concentration: Casual handwashing: 80,000 ppm (average) deliberate scrub: 120,000

**F. D. A. Strain (biological standard).

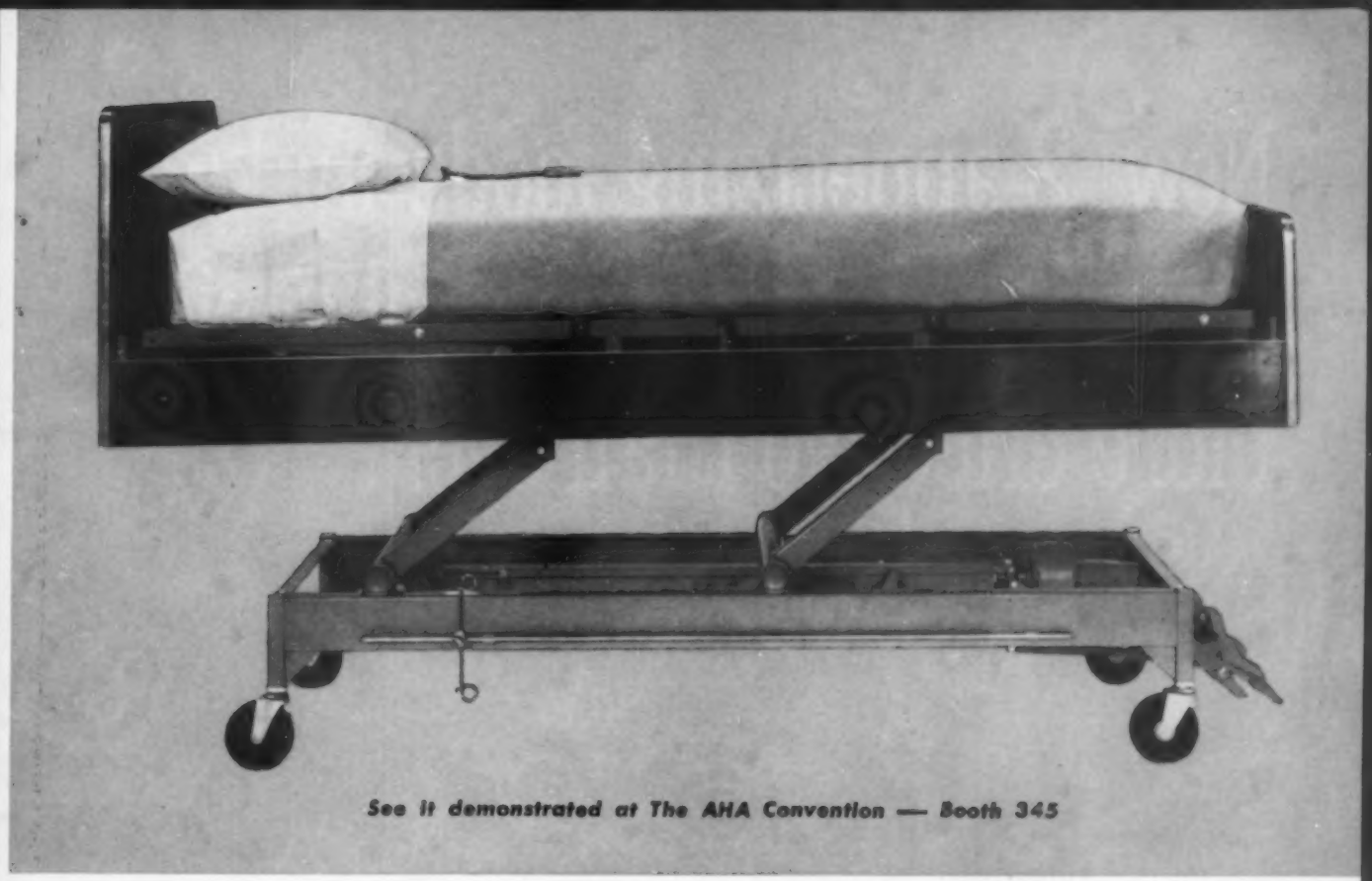
***Antibiotic-resistant strains supplied thru the courtesy of Mt. Sinai Hospital, New York, New York.



from the Industrial Soap Division of

ARMOUR AND COMPANY

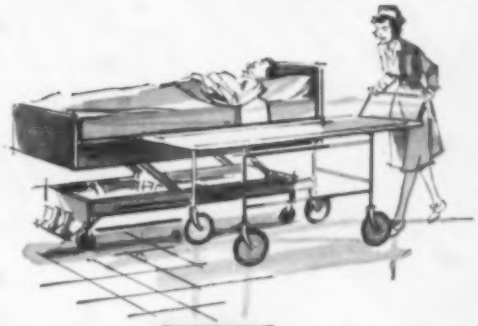
1355 W. 31st Street, Chicago 9, Illinois



See it demonstrated at The AHA Convention — Booth 345

This is the motorized bed that raises to FULL 34-INCH STRETCHER LEVEL

This is the new, fully motorized Borg-Warner hospital bed. It incorporates every feature we could think of to add to your convenience and efficiency. One example is its stretcher level high position. Not just 26 inches. Nor only 30 inches. But a full 34 inches from floor to top of spring sections. This is four to eight inches higher than any other motorized bed. It means quicker, easier, gentler transfer of patients from bed to stretcher, and back again. Other features of the Borg-Warner bed are equally notable. Including the cost, which is 20% to 30% less than other fully motorized beds. Full details are yours for the asking.





WITH NEW BORG-WARNER SELF-STORING SAFETY SIDE

INGERSOLL B-W PRODUCTS

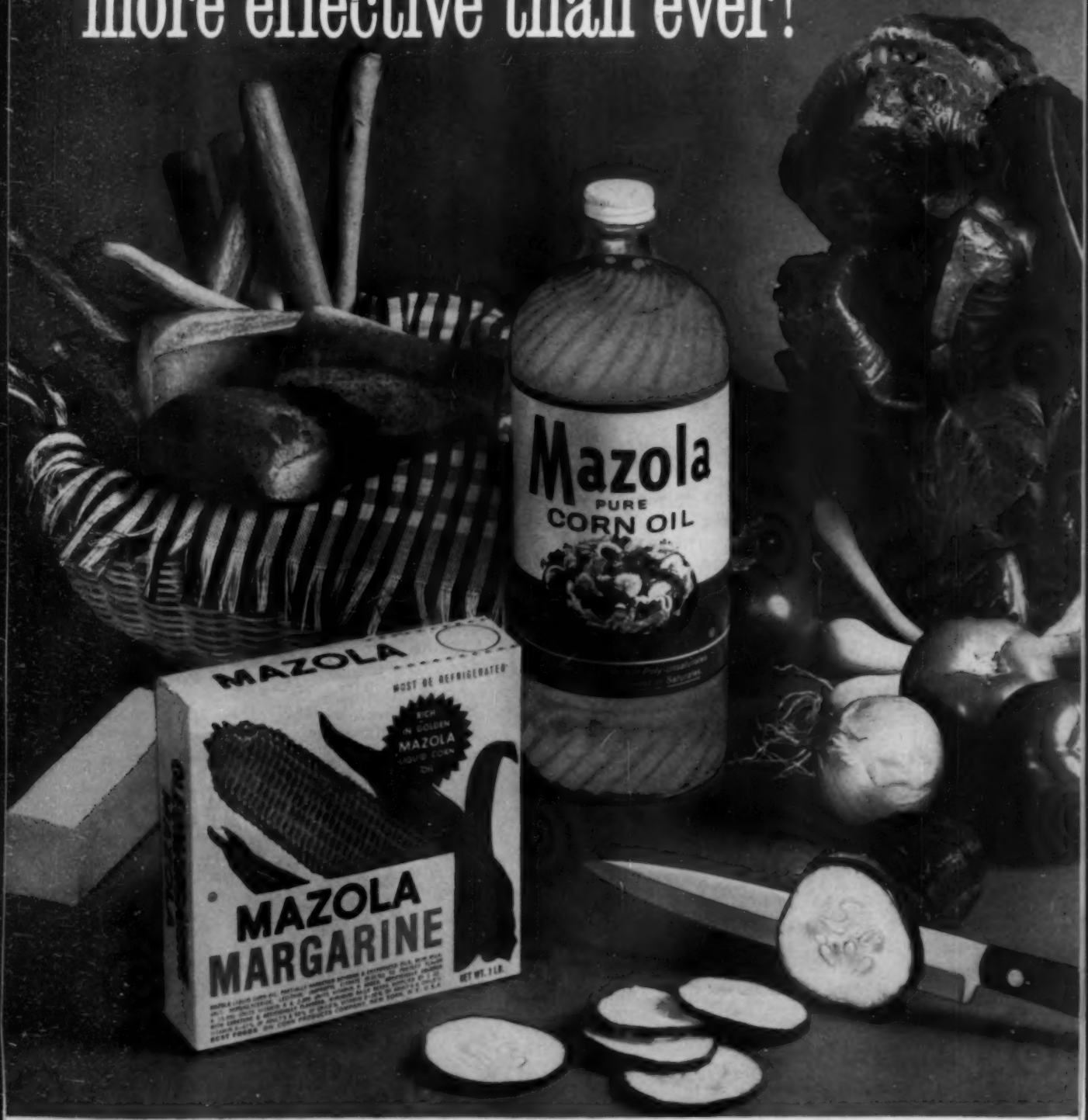
BORG-WARNER

Ingersoll PRODUCTS

DIVISION OF BORG-WARNER

1000 W. 120th Street, Chicago 43, Illinois

Now! 2 appetizing foods make serum cholesterol control easier, more effective than ever!



Your Patients Can Enjoy Fine Foods With Minimum Diet Changes!

For good eating while maintaining serum cholesterol control

Leading authorities agree that where reduction of serum cholesterol levels is indicated, fat intake should not exceed ⅓ of total calories and of this, at least ⅓ should be polyunsaturated fats.

Polyunsaturated fats, such as those found in corn oil, are rich in the linoleates which are important in reducing serum cholesterol levels. This has been proven time and again in nutritional studies of hypercholesterolemia. Mazola Margarine and Mazola Corn Oil have outstanding P/S (polyunsaturate to saturate) ratios. Thus the hypercholesterolemic patient can usually enjoy the same appetizing foods as the rest of the family.

Mazola Corn Oil is unexcelled in polyunsaturates and lowest in saturates of all leading brands of vegetable oils. Mazola's P/S ratio is far higher than that of any other leading food oil. Your patient will find Mazola Corn Oil ideally suited for salad dressings and frying; also for baking wherever *liquid* shortenings are called for in the recipe.

Mazola Margarine* contains *liquid* Mazola Corn Oil as a major ingredient. This corn oil is not hydrogenated, thereby preserving its rich content of linoleates. Mazola Margarine contains 2 to 3 times as much natural linoleates as any other margarine readily available in grocery stores from coast to coast. Its taste, color and handling characteristics are unexcelled.

*U.S. Pat. No. 2,955,039



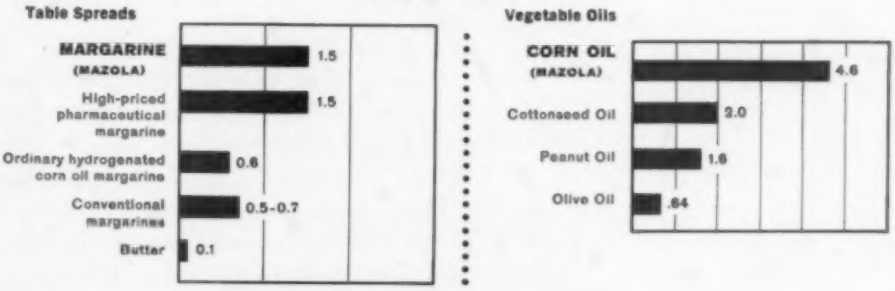


AVERAGE COMPOSITIONS OF MAZOLA® MARGARINE AND MAZOLA® CORN OIL
(All figures are in grams.)

	MAZOLA MARGARINE		MAZOLA CORN OIL	
	100 grams	2 oz. (4 tbsp.)	100 grams	1 fl. oz. (2 tbsp.)
Fatty Acids				
Polyunsaturated	21	12	51	14
Monounsaturated	40	23	32	9
Saturated	14	8	11	3
Natural Sitosterols	0.5	0.3	1	0.3
Natural Tocopherols	0.08	0.045	0.08	0.020
Cholesterol	none	none	none	none
Sodium	0.9	0.5	none	none

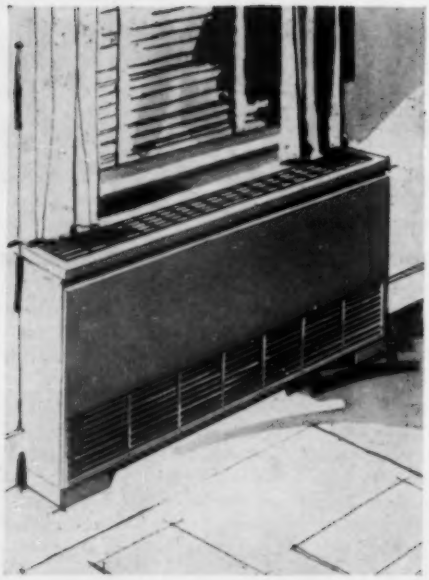
MAZOLA MARGARINE—410 Calories/2 oz.; Iodine Value—96
MAZOLA CORN OIL—250 Calories/fl. oz.; Iodine Value—124

RATIO OF POLYUNSATURATES/SATURATES
(Average values.)



CORN PRODUCTS COMPANY 10 East 56th Street, New York 22, N.Y.

For additional information, use postcard facing back cover.



New Carrier Weathermaster Unit comes complete with self-contained control that improves performance, eliminates water valve problems, reduces installation cost. It automatically maintains room temperature at level dialed by room occupant.

This Carrier air conditioning development solves hospital maintenance problems

Here's a technical breakthrough in air conditioning of special significance to all who are concerned with hospital management. Carrier engineers have perfected a means of using the well-known and extremely simple air bypass principle to achieve automatic capacity control of high-velocity induction units.

Air bypass replaces the mechanically more complicated regulation of water flow through the coil. This not only completely eliminates costly water valve maintenance problems, it also provides these additional benefits:

Better control—quicker, more accurate response

Silent action—no water surge or gurgle

Simplified installation—no pneumatic connections
—no water control valves
—no service valves at unit

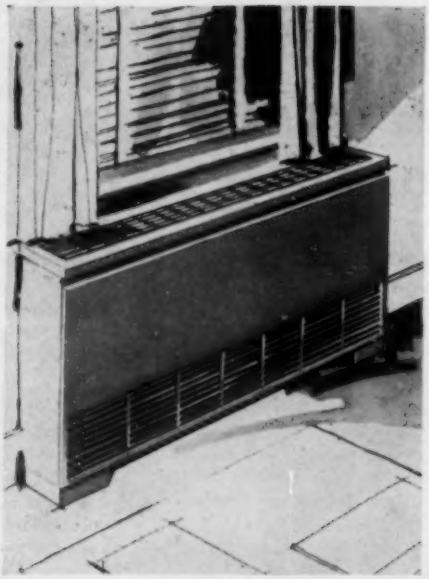
The Carrier Bypass Weathermaster* Units deliver only conditioned outside air—there is no recirculation of air between rooms. And where maximum filtering is desired, a chemically treated filter is available in lieu of a lint screen.

A Carrier representative will be glad to present the facts about the 36R Bypass Units to your architect and consulting engineer. Write Carrier Air Conditioning Company, Syracuse 1, New York. In Canada: Carrier Air Conditioning Ltd., Toronto.

*Reg. U. S. Pat. Off.

Carrier Air Conditioning Company





New Carrier Weathermaster Unit comes complete with self-contained control that improves performance, eliminates water valve problems, reduces installation cost. It automatically maintains room temperature at level dialed by room occupant.

This Carrier air conditioning development solves hospital maintenance problems

Here's a technical breakthrough in air conditioning of special significance to all who are concerned with hospital management. Carrier engineers have perfected a means of using the well-known and extremely simple air bypass principle to achieve automatic capacity control of high-velocity induction units.

Air bypass replaces the mechanically more complicated regulation of water flow through the coil. This not only completely eliminates costly water valve maintenance problems, it also provides these additional benefits:

Better control—quicker, more accurate response

Silent action—no water surge or gurgle

Simplified installation—no pneumatic connections
—no water control valves
—no service valves at unit

The Carrier Bypass Weathermaster* Units deliver only conditioned outside air—there is no recirculation of air between rooms. And where maximum filtering is desired, a chemically treated filter is available in lieu of a lint screen.

A Carrier representative will be glad to present the facts about the 36R Bypass Units to your architect and consulting engineer. Write Carrier Air Conditioning Company, Syracuse 1, New York. In Canada: Carrier Air Conditioning Ltd., Toronto.

**Reg. U. S. Pat. Off.*

Carrier Air Conditioning Company



The furniture you select for the new patient room COULD make your new hospital OBSOLETE the day you open it!

← BUT NOT IF YOU

Choose the new kind of furni




niture that cares for patients
AMERICAN SEATING

Walk around...

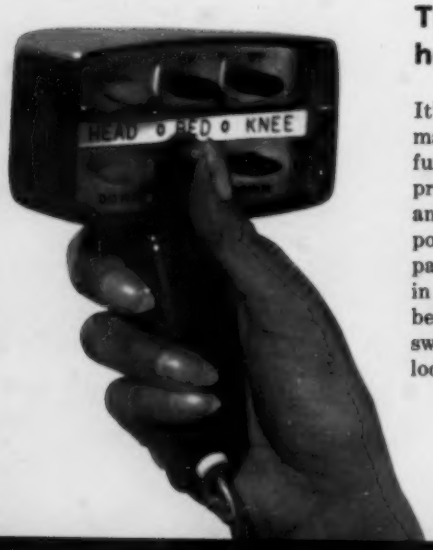
Just *one* of the nice things about American Seating's new patient-room furniture is the way it makes the room a pleasure to be in, a pleasure to work in. Hospitals all over America are using this furniture. They're finding it's the best insurance they can have against early obsolescence.

American Seating has thought of the most important things—with an eye to the comfort and convenience of *both* patient and nurse. Patients *do* more for themselves. Doctors and nurses enjoy more efficient use of their time.

For instance, the Access-o-matic bed adjusts instantly to the touch of a button . . . yet, a key-operated switch leaves the nurse in command. Both head- and footboards remove easily. And the Bedside Susan is full of surprises that evoke a smile when, for example, the top is swung away to reveal a tray for personal effects.

Moreover, there's the down-to-earth practicality of American Seating furniture: a lounge chair that easily changes position by a shift in weight; a molded bench with drawers under or a three-drawer chest on top, with colors and finishes to fit *your* hospital.

All this is true of American Seating's new patient-room furniture and more. But *you* won't be satisfied until you've seen a demonstration. And when you've seen a demonstration you won't be satisfied with anything less than American Seating. Ask to see it.

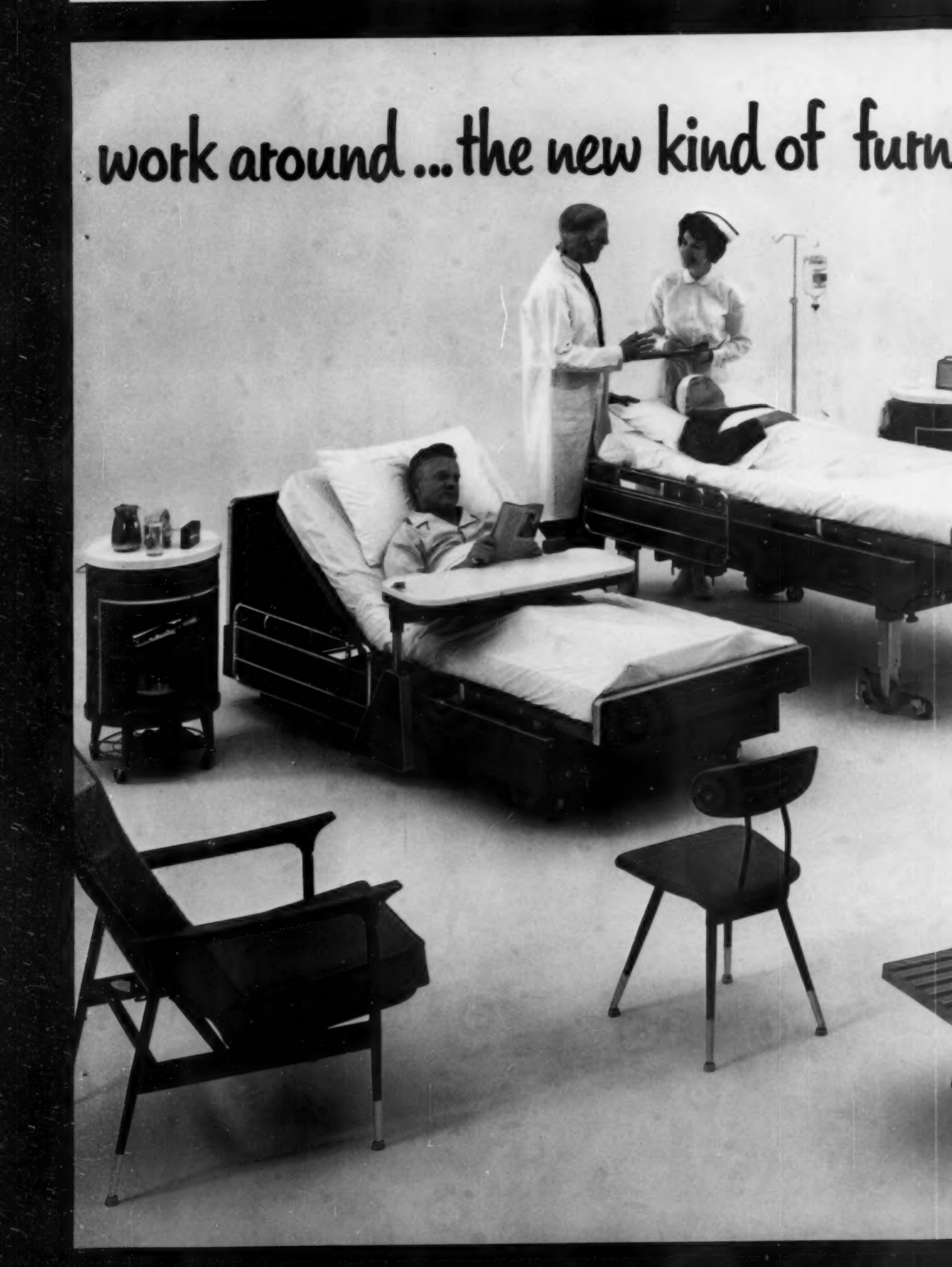


The Push-Button Control—heart of Access-o-matic bed

It's colorful. It's lightweight. It's one of the main reasons why American Seating hospital furniture *cares for patients.* Just finger-tip pressure on the sculptured control buttons and bed adjusts to any desired height, or position for head or knee section. Lets patients do more for themselves! When not in use, fits handily in "caddy" affixed to Overbed Butler or bedside. Key-operated electrical switch at foot end of bed allows nurse to lock bed in any desired position.

Copyright 1961, American Seating Company.
American Seating products are fully covered by patents and patents pending.

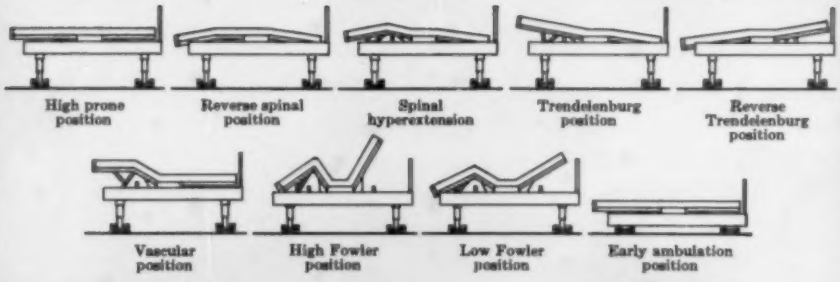

vork around ... the new kind of fu


work around ... the new kind of furn


niture that cares for patients
AMERICAN SEATING



Double-exposure photo shows Access-o-matic bed in low (14 inches) and high (29 inches) positions. Touch of a button adjusts bed to all standard treatment positions. Headboard is removable; footboard drops down to extend bed length to 90 inches. Half- or full-length side rails available.





Bedside Susan features a swivel top, compartment underneath, towel bar and slipper rack. Front half of cabinet slides open for access to revolving shelves.



Companion side chair for patient or waiting rooms, offices, lobbies. Has washable vinyl upholstery. Padded back adjusts automatically. Metal parts furnished in baked enamel mix-or-match colors.



Handsome, two-position Rest-O-Matic Lounge Chair adjusts from erect to reclining position merely by shifting body weight. Decorator styled, luxury-depth washable seat cushions.

Contemporary bench and chest performs dual function for space-saving and convenience. Attractive decorator colors, unlimited mix-or-match furniture combinations, 4- and 6-foot bench lengths. Plastic surfaces for low maintenance.



AMERICAN SEATING

GRAND RAPIDS 2, MICHIGAN

MANUFACTURERS OF SCHOOL, CHURCH AND HOSPITAL FURNITURE; AUDITORIUM, STADIUM, THEATER, AND TRANSPORTATION SEATING; FOLDING CHAIRS AND TABLES

Access-o-matic, Overbed Butler, Rest-O-Matic Lounge Chair, and Bedside Susan are trademarks of American Seating Company.

FORM 6585-3 LITHO IN U.S.A.



this is the ICE MAKER preferred by so many hospitals

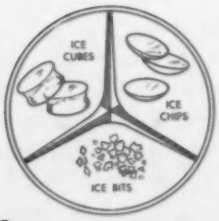
Large and small hospitals everywhere use Crystal Tips ice makers. Such well-known places as Fitzsimons General Hospital in Denver, Colorado; Orange Memorial Hospital in Orange, New Jersey; National Institute of Health in Bethesda, Maryland; Matteawan State Hospital in Beacon, New York; Presbyterian Hospital in Charlotte, North Carolina; Veterans Administration Hospital in Iowa City, Iowa; and General Hospital in Minneapolis, Minnesota, use Crystal Tips ice. If you compare size, dependability, installation costs and initial investment, you will see why Crystal Tips is preferred by so many hospitals and is your best buy in automatic ice machines.

Crystal Tips 2-in-1 ICE MAKERS

Hundreds of hospitals use Crystal Tips 2-in-1 ice makers to fill their round-the-clock need for fresh, pure ice. The Crystal Tips Model B-500 (air or water cooled models) is a favorite with hospitals. It automatically makes, delivers and stores hundreds of pounds of ice per day for less than a dollar a day. No other ice maker of similar size or price can match Crystal B-500 big production – up to 555 pounds per day.

Crystal Tips 2-in-1 ice makers give you a choice of large, round, clear cubes or tasty, fast-cooling ice chips. Just flip the ice selector dial to "cubes" or "chips" and your Crystal Tips ice maker does all the rest automatically.

In all, there are twenty-six different models of Crystal Tips ice makers from which to choose. In addition to 2-in-1 ice makers, Crystal Tips offers the newest, most advanced flaked ice makers available. Whatever your needs, Crystal Tips has a model that is just right to match your ice requirements and your budget. Write for free literature about Crystal Tips ice makers. Why not make inquiry today?



Crystal Tips

First Name in Automatic Ice Makers

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1789 Park Avenue N.W. • Faribault, Minn.

A Division of McQuay, Inc.

Gentlemen: Please send me, without cost or obligation:

- ☐ Detailed literature about Crystal Tips ice makers. We need approximately_____lbs. per day.
- ☐ Send details about locating ice makers on individual floors.
- ☐ Please have representative contact me.
- ☐ We now are equipped with ice makers but are interested in comparing Crystal Tips with our present service.

Name_____

Name of Hospital_____

Address_____

City_____State_____

ON DISPLAY IN ATLANTIC CITY AT A.H.A. EXPOSITION, SEPT. 25-28. VISIT BOOTH 471



He's alive...

He's alive . . . little Neil Kaplan is alive. This fact would once have seemed a miracle.

Four-year-old Neil became sick on December 5, 1960. He felt hot, his head hurt, he could hardly move his neck, he became rapidly worse. Rushed from his home in New Jersey to The Children's Hospital of Philadelphia, he was semiconscious when admitted . . . his fever 104 degrees. Preliminary diagnosis: meningitis, an infection that attacks the delicate tissues surrounding the brain.

Neil was given the first of what were to be many massive doses of sulfa drugs and antibiotics. A battery of laboratory tests confirmed the diagnosis and identified the deadly bacteria. Doctors and nurses worked around the clock, administering drugs and comfort to their small patient, watching over him and recording every change in his condition. Within a week, Neil Kaplan was out of danger.

He's home now, recovered from influenza meningitis. The rate of death or of permanent brain damage from this virulent disease before drugs became available to treat it: virtually 100 per cent.

Neil's recovery was no miracle. It resulted from the skill and dedication of the physicians who treated him, from the expert training of those who aided them: nurses, laboratory technicians, pharmacists, other members of the hospital staff. It resulted from the precisely integrated organization and superb facilities of today's hospitals. But it would not have been possible at all without modern drugs.

Neil Kaplan is one of the many millions of Americans who might be dead or seriously incapacitated today were it not for the astounding fact that in the last two decades greater research progress has been made in the discovery and development of drugs than during the preceding two centuries. These new drugs, the great majority of which weren't available even ten years ago, have helped empty T.B. sanatoriums; helped lower the population of mental hospitals; effectively treated or prevented a host of killers, including—among many others—scarlet fever, pneumonia, venereal diseases, rheumatic fever, arthritis, certain heart disorders.

In 1960 alone, the American drug industry spent an estimated $214 million for research. Much of this effort was expended on research "gambles" that never came off; for in all research, failure is much more common than success. But the successes have had a tremendous impact on the nation's health.

SK&F Smith Kline & French Laboratories, Philadelphia

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SQUARE
PRESSURE
STERILIZERS



Recessed or Cabinet Models . . . 16″x 16″x 24″ or 20″x 20″x 36″ chamber sizes

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For example, in just a few minutes this O. R. Nurse will return to surgery with a tray of sterile instruments, ready for the surgeon's immediate use . . . thanks to Amsco's high speed Pressure Instrument Sterilizer.

Final assurance of the reliability of these superior sterilizers is provided by the most positive sterilizer control ever designed . . . Cyclomatic . . . a device at eye level which automatically programs the selected cycle from start to finish, without attention from the operator.

Square Pressure Sterilizers may be adapted at the factory to meet your specific needs. Write for bulletins SC-362 and SC-312.

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Castle POWERCLAVE*

with ELECTRILOCK DOOR

SAFER . . . Just a touch of a button closes and locks the door. Steam tight seal is automatic—regardless of the operator's strength. And three separate features make it impossible to open the door under pressure.

EASIER . . . No handwheel to struggle with. It's all automatic. Closing and locking the door, sterilizing, opening the door—it's pushbuttons all the way!

MORE CAPACITY . . . New design of vessel and car increases load capacity. And improved exchange of air and steam reduces cycle time—particularly advantageous with high vacuum techniques.

THAN EVER BEFORE! POWERCLAVE is the first major re-design of hospital sterilizers in forty years. Yet you can fit it right into your present sterilization program—for approximately the cost of a conventional autoclave! Write for POWERCLAVE literature.



Open! Just push the button. Door swings out smoothly, silently—*effortlessly.*



Load! New LoadMaster Car and Safe-T-Lock Carriage handle larger loads, more safely.



Lock! Touch the button—door swings shut, locks safely, starts sterile cycle. No handwheel to wrestle with.

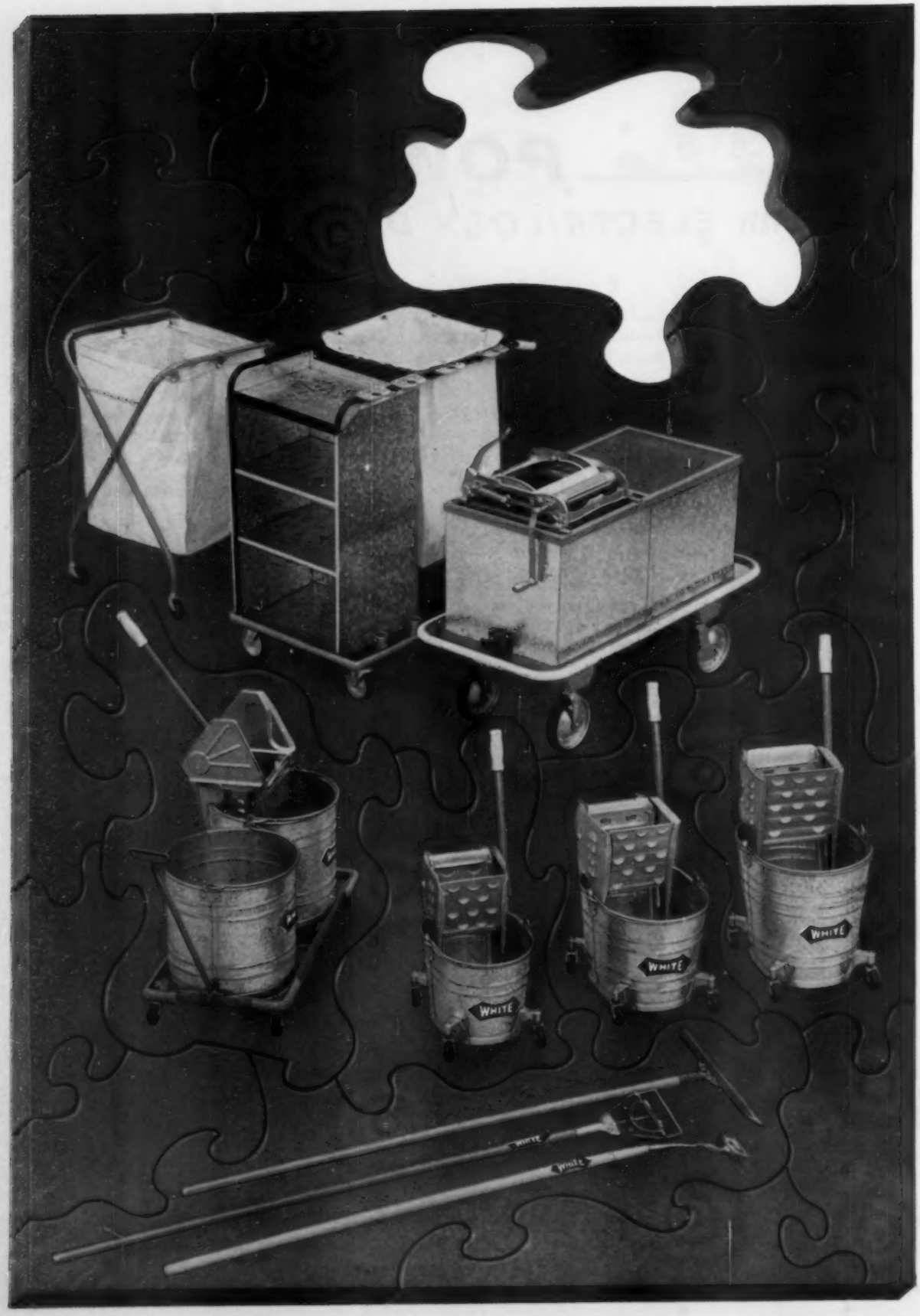
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We dedicate ourselves to patient welfare.

WE INTEND

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- ★ to program economic assistance to (id est, save money for) nursing homes and chronic hospitals.
- ★ to help our medical and hospital equipment dealers sell our products with workable sales programs.



This will lower the costs of patient care for the hospital, the nursing home and the bedfast patient at home.

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Suppositories **DULCOLAX®**
brand of bisacodyl

the laxative that replaces the enema effectively

discontinuing enemas means reduced laundry costs
A Dulcolax suppository induces a bowel evacuation within an hour, usually in about 30 minutes. It has proved to be at least as effective, and often more effective, in emptying the bowel than ordinary cleansing enemas. And as action is gentle without purgation, soiling of linen is avoided.

discontinuing enemas saves personnel time... saves cost of cleaning equipment
Dulcolax eliminates the most unpleasant duty that nurses and ward personnel have—the routine administration of enemas. Furthermore, ward duties relative to bowel care can be completed by 9:00 or 10:00 A.M., freeing personnel for other work. And, of course, there's no enema equipment to clean.

Dulcolax may also be used to advantage pre- and postoperatively and in preparation for X-ray or proctosigmoidoscopy.

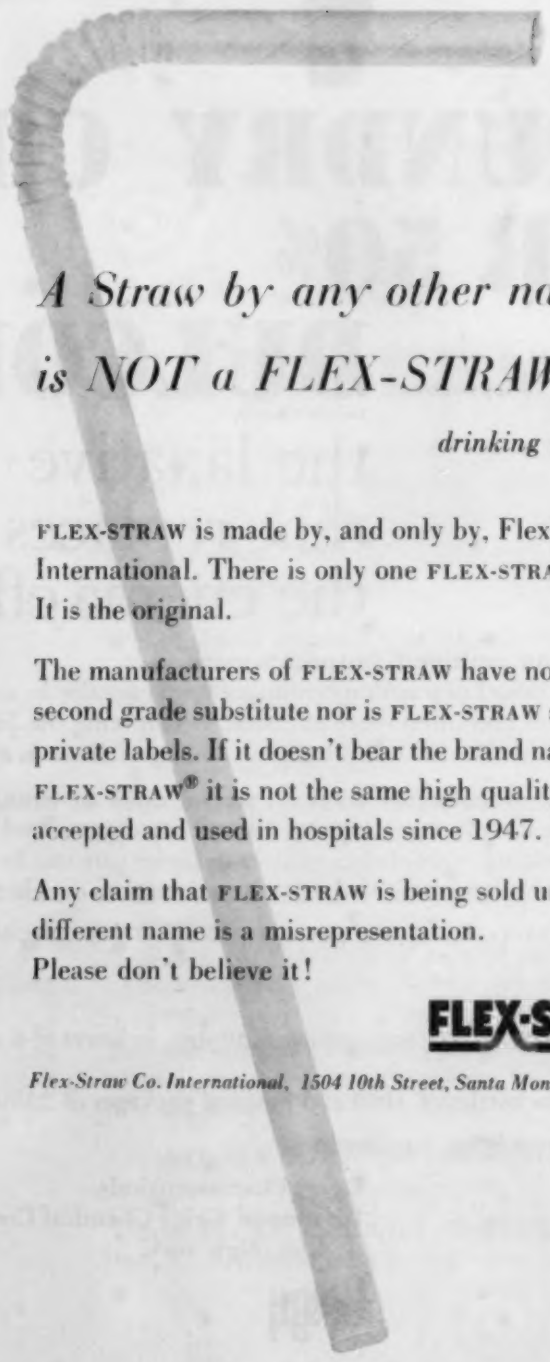
Dulcolax®, brand of bisacodyl, is available as: Suppositories, 10 mg., in boxes of 6 and 48 and hospital packages of 500.
Also available as: Tablets, 5 mg., in bottles of 1000 and hospital packages of 2500 and 5000.

Under license from C. H. Boehringer Sohn, Ingelheim.

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Geigy

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A Straw by any other name

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FLEX-STRAW is made by, and only by, Flex-Straw Co. International. There is only one FLEX-STRAW. It is the original.

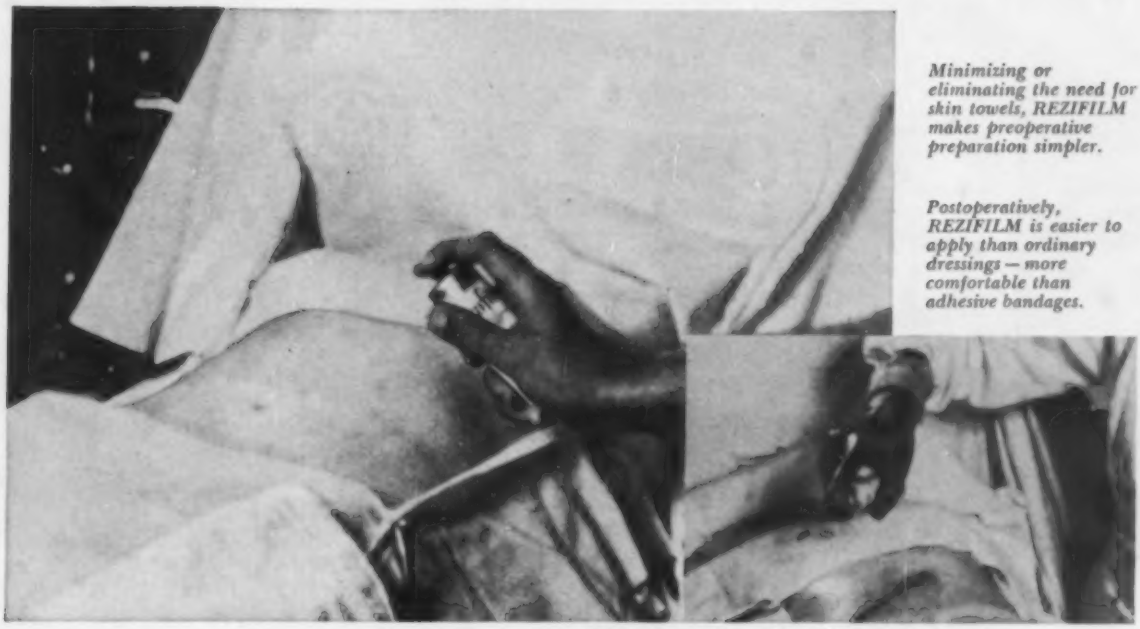
The manufacturers of FLEX-STRAW have no second grade substitute nor is FLEX-STRAW sold under private labels. If it doesn't bear the brand name FLEX-STRAW® it is not the same high quality product accepted and used in hospitals since 1947.

Any claim that FLEX-STRAW is being sold under a different name is a misrepresentation. Please don't believe it!

FLEX-STRAW®

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spray-on surgical film controls bacteria— even resistant "staph" and "gram-negs"



Minimizing or eliminating the need for skin towels, REZIFILM makes preoperative preparation simpler.

Postoperatively, REZIFILM is easier to apply than ordinary dressings — more comfortable than adhesive bandages.

Rezifilm®

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transparent plastic barrier with antibacterial action

REZIFILM — spray-on methacrylate resin — forms a clear, firm, flexible barrier against air-borne microorganisms. This physical protection is supplemented by thiram (tetramethylthiuram disulfide) — an antibacterial agent highly effective against a wide range of pathogens, including many resistant to antibiotics.[1] Thiram readily diffuses to the skin, providing enhanced preoperative and postoperative asepsis. Incision may be made directly through the film.[2]

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For full information see your Squibb Product Reference or Product Brief.

References: 1. Eisenberg, G. M., Weiss, W., Spivack, A. P. and Flippin, H. F.: *Antibiotic Med. & Clin. Ther.*, 6:594 (1959). 2. Thomson, J. E. M.: Clinical Research Notes, Vol. 3, #3, p. 1 (1960). 3. Kanof, N. B., and Blau, S.: *Arch. Dermatol.* 83:503 (1961). 4. Bronwell, A. W.: Clinical Research Notes, Vol. 3, #3, p. 6 (1960).

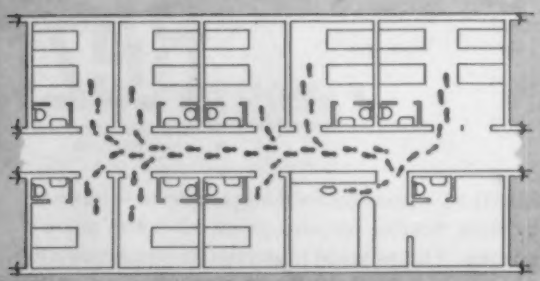
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Easier-to-use master station and latest style telephone speed handling and simplify answering of patients' calls. Calls can be answered in succession or by selection. Nurse can contact any room to talk with patient or to monitor the room... can make calls to all rooms simultaneously... communicate with duty or utility rooms.



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THE STANDARD ELECTRIC TIME COMPANY

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NURSE SAVER® II

the ALL NEW Versatile Nurse-Call System

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System adapts easily to any hospital's method of operation. Flexibility features include: interchangeability of bedside stations (pull cord or push button); availability of a variety of nurse-call stations, emergency stations, duty stations, etc. which can be positioned as desired; use as an "all call" system.

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Latest in amplifier design and circuitry means markedly superior voice reproduction.

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Designed specifically for dependable operation under conditions of continuous, 24 hour duty. Produced by STANDARD—leader in development of quality electrical systems for 75 years.



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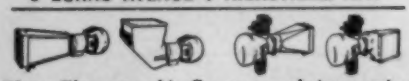


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*R48 single plug-in.

R47 single plug-in with unique Y-site for supplemental medication.

R49 Y-type for alternate or simultaneous administration of blood and solution.

BAXTER LABORATORIES, INC. MORTON GROVE, ILLINOIS

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AMERICAN HOSPITAL SUPPLY CORPORATION
Scientific Products Division General Offices, Evanston, Illinois

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while simplifying figure work with the *National** DELUXE ADDING MACHINE



with "Live" Keyboard

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Only National has 14 time- and money-saving features.

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Your business, too, can benefit from the many time- and money-saving features of a National adding machine. Nationals pay for themselves quickly through savings, then continue to return a regular yearly profit. For more information, call nearest National branch office or dealer. See phone book yellow pages.

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NCR PAPER (NO CARBON REQUIRED)

THE NATIONAL CASH REGISTER COMPANY, Dayton 9, Ohio
1039 OFFICES IN 121 COUNTRIES • 77 YEARS OF HELPING BUSINESS SAVE MONEY



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IT WILL:

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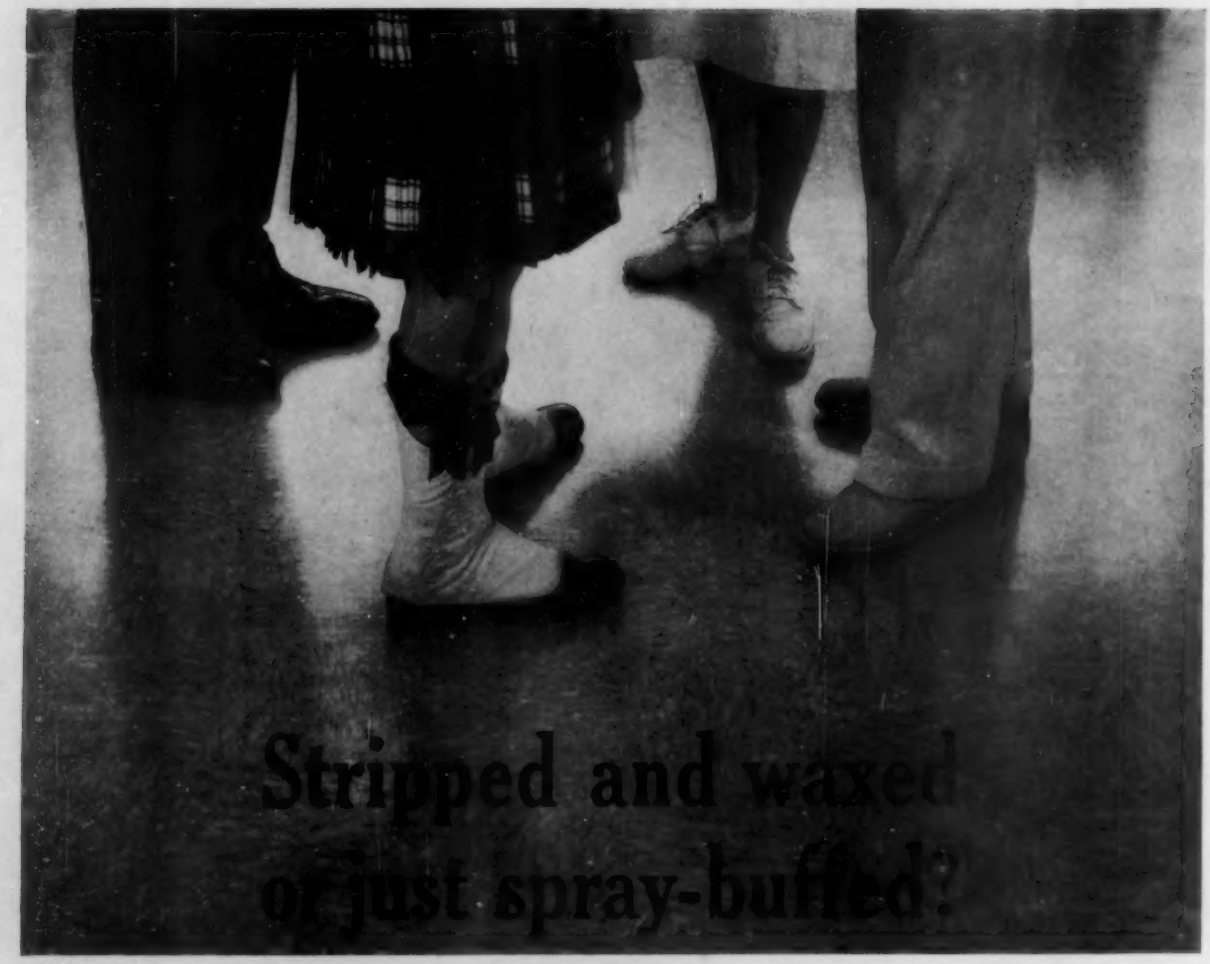
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3M System keeps floors so new looking you can hardly believe your eyes . . . . .

Now with 3M's new spray method and "SCOTCH-BRITE" Floor Maintenance Pads you can keep floors new looking week after week after week. This new spray method lets you clean and polish floors in one simple operation. Your floors are kept at a higher level of appearance with less strippings.

The 3M spray method and "SCOTCH-BRITE" Pads can give you dramatically pleasing results on even your heaviest trafficked floor areas. These unique non-woven Nylon pads never splash or rust . . . can be rinsed in water, dried quickly and re-used. Let us show you how regular floor care with "SCOTCH-BRITE" Pads can cut your maintenance costs and improve your floor appearance. For a free demonstration on your floors, write: 3M Co., Dept. ABY-91, 900 Bush Ave., St. Paul 6, Minn.



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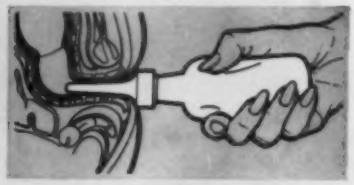
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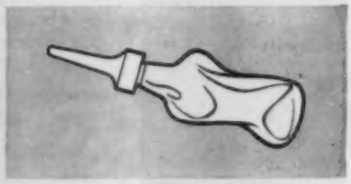




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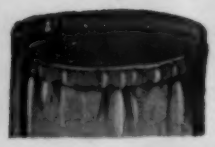
Angelica's designers work with hospital personnel to improve the protective capabilities of surgical garments. Ideas to increase comfort and convenience are also thoroughly researched—designs are tested and evaluated by doctors, nurses, housekeepers and laundries in leading hospitals. Here are several products of Angelica's "living research."





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Scrub nurses will welcome this new dress which opens from neck to waist in back, making it easy to step out of or into. Eliminates facial contact with perspiration or blood stained garments.





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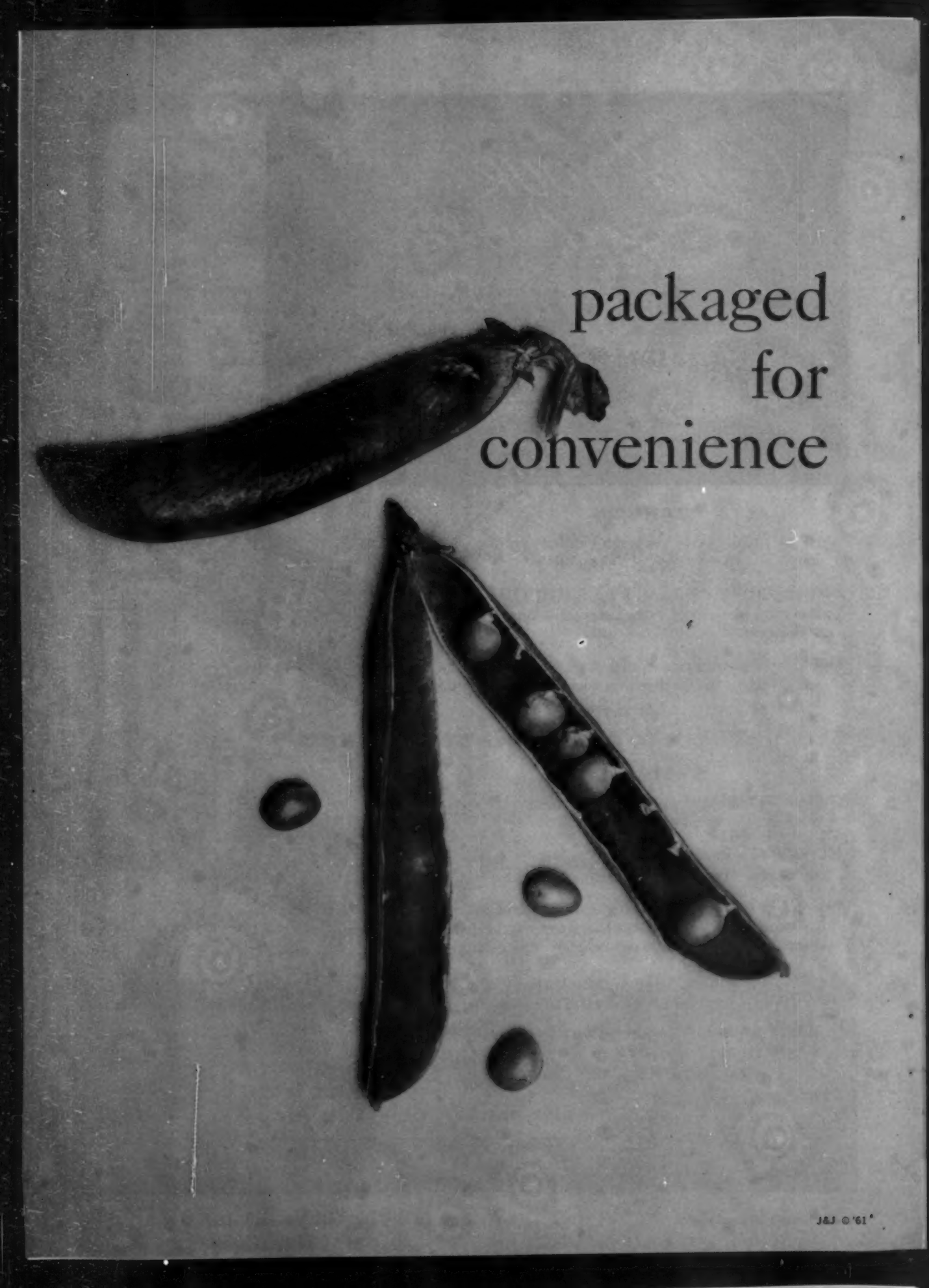
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The new 764 Thermotic Drainage Pump featuring a convenient, compact flushing attachment, speeds and simplifies flushing and drainage techniques.

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Dependable, attention-free Drainage Pump then gently and automatically withdraws the flushing solution to complete the cycle.

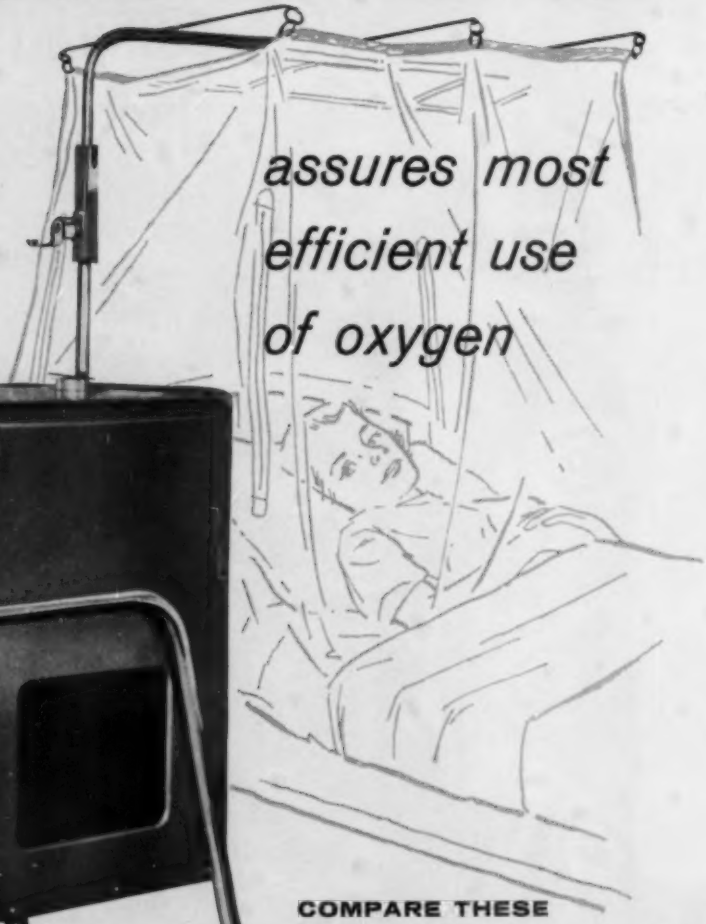
Hospital tested and approved, Gomco No. 764 Thermotic Drainage units are designed for procedures requiring suction as mild as 120mm or 90mm mercury. Baked Lumitone finish, Formica tops, chrome-plated fittings, and Aerovent Overflow Protection are standard equipment.

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New Lake County, 5-Building, 4-Story Convalescent Home Housing 200 elderly Residents.



Architects & Engineers: Beine-Hall & Curran, Gary, Ind.
Contractor: Morrison, Inc. Hammond, Ind.

Lake County Installs All DUNHAM-BUSH Heating in New Convalescent Home at Crown Point, Indiana

Lake County commissioners and their Architects and Engineers have created a new concept of physical care facility in their new convalescent home. The home, open to elderly persons regardless of financial status, alleviates a common over-crowded hospital situation. Dunham-Bush contributes to Lake County Convalescent Home comfort (and economical operation) thru: Thermovector Radiation in Ward Rooms and Corridors; Special Two-row Radiation in Administration Building; Cabinet Heaters in Sun Rooms; Heating-Ventilating Units, Ceiling Cabinet Heaters in Cafeteria plus Condensation Pumps and Heating Specialties. There's a place in your convalescent home or hospital planning for Dunham-Bush. Write today for full details.



Typical Ward Room for 4 Persons is Heated with Dunham-Bush Radiation.



Corridor showing Dunham-Bush Radiation.



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Yet, we find many hospitals base their conversion to Amsco on the fact that we offer the profession not only a complete line of solutions and blood apparatus, *but also "highly specialized" solutions and equipment for intricate procedures.* These hospitals, too, are correct in their reasoning, for each conveniently located Amsco warehouse and American Sterilizer office is fully equipped to provide hospitals with their *entire* Parenteral Fluids program.

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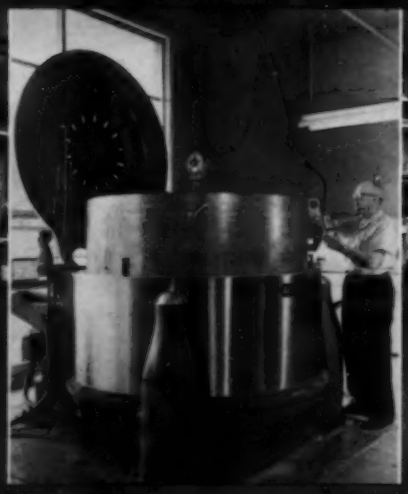
At Long Beach, Calif., Community Hospital . . .

Modern, automatic American-equipped laundry means

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— 280 hrs/week (7 fewer operators)

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This is possible because modern, automatic laundry equipment strikes at the heart of the manpower problem. Your laundry is one of the few departments where the work can be done by machines instead of people. That's why an investment in modern equipment brings immediate and sizable returns.

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A. Just press a button and these big-volume CASCADE® Unloading Washers in Long Beach Community Hospital laundry are unloaded effortlessly. Automatic washing controls regulate the entire washing cycle to save operator's time, increase production and assure uniform high-quality washing.

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American

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Need another pair of hands in your pharmacy?

IF YOUR HOSPITAL is as overcrowded and as overworked as 90% of the hospitals today, you certainly need extra help. What a good many hospital pharmacists and administrators do not know, however, is that they can get the extra pharmacy help without increasing their operating costs. As a matter of fact they can even save money while increasing efficiency.



● The McKESSON & ROBBINS Hospital Service Representative will gladly become your extra man. He is more than a salesman, he is a trained hospital pharmacy specialist who can give you professional assistance and advice on the many problems of hospital drug management.

Take your drug inventory for example. Large inventories eat up valuable time in ordering and maintaining stock levels and crowd your space, but, more importantly, they increase your carrying charges, tie up money and increase the risk of loss due to deterioration, damage and obsolescence. The McKesson & Robbins Hospital Service Rep can help you establish a smaller in-hospital inventory based on sound drug levels in keeping with your medical needs. He will also help you select drugs produced by reliable manufacturers to meet your demands—and then will maintain your stock levels for you. This means the money and time costs of procuring and carrying supplies will be held at a minimum. A real saving for you.

With 91 McKesson & Robbins warehousing units across the country, each with a Hospital Service Department, you have a local source of drug and sundry supplies that is actually an extension of your own storage space. You are only a telephone call away from any drug product you might need in emergencies, as well as for routine service. Inventory control is but one of the reasons why most of the nation's hospitals depend upon McKesson & Robbins for economical and efficient management of their pharmacies.

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SMALL HOSPITAL QUESTIONS

What Nursing Home Accounts Are Needed?

Question: Are accounting methods for a nursing home the same as for a hospital?—F.W., S.C.

ANSWER: Because most nursing homes do not require nearly as many account categories as do hospitals, their accounting system can be much simpler. A recent United States Public Health Service publication entitled, "A Suggested System of Uniform Expense Accounting for Nursing Homes and Related Facilities," is an excellent guide designed to help administrators of nursing homes record their expenses uniformly. The manual, as its introduction states, "provides a relatively simple system of expense accounting that may be adapted to meet both the internal needs of a facility and various outside reporting requirements."

It includes a detailed description of how to establish a useful chart of expense accounts, a discussion and explanation of nursing home accounting procedures and records, and a generous group of illustrations that show recommended forms, ledgers, statements, payroll and general journals, and so forth.

Single copies of the manual, P.H.S. Publication No. 835, may be obtained from the Division of Hospital and Medical Facilities of the Public Health Service, Washington 25, D.C. Additional copies may also be purchased from the Superintendent of Documents, U.S. Government Printing Office, Washington 25, D.C., for $1 per copy.

Let Costs Dictate Charges

Question: What is generally meant by the statement that specific charges to patients should be related to actual costs? – L.K., W. Va.

ANSWER: In some hospitals, charges for ancillary services are pegged high and do not relate in an equitable manner to the cost of these services. When this happens, the hospital involved is not so much concerned with making a profit as with compensating for losses incurred by other departments or by a low daily room rate. Nevertheless, in these situations the public often feels that it is being overcharged and has trouble understanding or sympathizing with the reasons for it.

Speaking to this point at a recent meeting of the Colorado-Wyoming chapter of the American Association of Hospital Accountants, Rodney Rassmusson, Englehardt and Co., St. Paul, stressed the great need for hospitals to find their true departmental costs and apply these findings to hospital rates and charges. Present rates, he warned, are too often "a hodgepodge built up in a crazy-quilt arrangement."

Cost allocation, he said, "is not a gimmick." It helps, he explained, in determining rates, measuring departmental efficiency, and in achieving better management control.

Hospitals, he emphasized, must put themselves in a position where they can satisfactorily explain why their rates are what they are, so that they can convince the public that they are not overcharging.

Optimum Occupancy Rates

Question: What occupancy rate is generally considered desirable for major clinical services? – E.K., Ga.

ANSWER: Many consultants believe that occupancy for such services should be quite high in the interests of efficiency. A new report* on planning prepared by a joint committee of the American Hospital Association and the U.S. Public Health Service states that the optimum occupancy for units with medical and surgical patients might be set from 85 to 90 per cent.

"These relatively high rates," the committee points out, "are made possible by the larger number and greater interchangeability of beds on these services and by the fact that some admissions are elective and subject to control."

*Areawide Planning for Hospitals and Related Health Facilities. U.S. Department of Health, Education and Welfare, Public Health Service, Washington, D.C.

ANY QUESTIONS?

The Modern Hospital will be glad to try to answer them.

If you have a problem or if you're just curious about a procedure or a statistic, please feel free to write this department, care of The Modern Hospital, 1050 Merchandise Mart, Chicago 54.

Package Plastic Silverware

Question: I am writing for information concerning plastic silverware. The kind of silverware we have in mind is similar to that used by airlines, and would, of course, have to be fairly sturdy. We would prefer to buy this plastic silverware wrapped in cellophane. If it contains a napkin, and so forth, that would be fine. – D.T., N.C.

ANSWER: Plastic silverware of this type is obtainable from several sources. However, it would be less expensive for you to buy the individual plastic pieces and use hospital personnel to assemble them in cellophane bags. – JANE HARTMAN

Time for Proper Heat

Question: How long should it take for the thermometer on a sterilizer to reach a temperature of 250 F.? – H. M., Nev.

ANSWER: If the sterilizer is less than 60 inches long and is functioning properly, the chamber temperature will reach 250 F. within five to 10 minutes. The time interval is, of course, to some extent dependent on the size of the sterilizer.

The best source of immediate information on this subject would be the distributor or manufacturer of the particular sterilizer in question.

What To Wear in C.S.S.

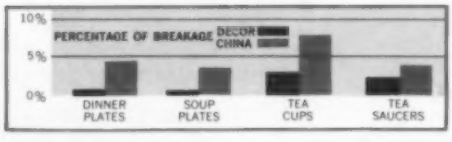
Question: Should central service employes wear scrub dresses? – W.B., Kan.

ANSWER: They can. Cleanliness of the garment is the important factor, rather than what type of uniform is worn.

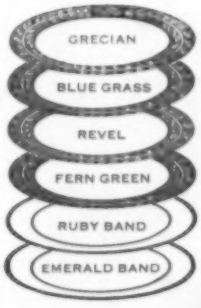


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WHERE HEALTH LEGISLATION STANDS

For the last few weeks Congress has been boiling with talk on health bills. There is testimony, argument and backstage bickering. Yet no one expects any dramatic developments in the short time before a scheduled mid-September adjournment.

On the most important measures — drug control, medical care for the aged, and federal aid to medical and dental schools — nothing more will be done this session. The community facilities bill, which has passed the House, is stalled in Sen. Lister Hill's labor and public welfare committee, mostly because Senator Hill still is not resigned to letting this program operate outside the Hill-Burton controls.

Here is the situation regarding the top priority health measures:

APPROPRIATIONS:

The Hill-Burton hospital construction program is assured of at least as much money as it had last year ($187.9 million), and it may wind up with considerably more.

While the House went along with this Budget Bureau approved figure, the Senate upped it to $212.9 million. A compromise at about $200 million is likely.

The H-B appropriations became involved — with all other money for Public Health Service and the National Institutes of Health — in a legislative tangle that delayed appointment of House members to a conference committee which will settle the issue. Rep. Melvin Laird (R.-Wis.), irritated because both White House and H.E.W. had ignored his requests for more information on how N.I.H. proposed to spend its increases, raised objection to appointment of the conferees until he obtained the answers to his questions. But Mr. Laird could stall action for only a limited time — passage of the bill was assured.

On H-B funds, the House had increased money for specialized facilities by $25 million, but had lopped the same amount off general hospital construction grants. The Senate let the $25 million extra remain for specialized construction, and added the same amount to the general hospital account.

In explanation for the over-all $25 million increase, the Senate appropriations committee explained that if matching federal funds were available, states were prepared to put up their share to ensure building of 43,754 new general hospital beds. This would call for $400 million from the U.S. "Although the authorization of $150 million is far short of this level," the Senate report said, "the provision of that amount will permit greater progress to be made toward reducing the present substantial deficit of general hospital beds and related facilities."

In other items, the money bill provides between $9 million and $10.6 million for more research, demonstration projects, and personnel training in radiological health problems; and $49.8 million (same as last year) for Public Health Service hospitals and medical care. A substantial improvement is anticipated in staffing for operating personnel at P.H.S. hospitals and a slight increase in hospital research.

MEDICAL CARE FOR AGED:

Chairman Wilbur Mills of the House ways and means committee reluctantly conducted two testimony-packed weeks of hearings on President Kennedy's plan for medical care of the aged under social security, after making it plain that this was just window-dressing, that the committee would take no further action on the bill this year.

In all, 141 associations and individuals were heard at the sing-song sessions, where almost no new ideas were produced and few new faces appeared. Several hundred other associations submitted statements for the record, or said they would. Some highlights:

H.E.W. Secretary Ribicoff didn't waste much time arguing that there was a problem in financing medical care for the aged — his premise was that a problem existed and that the task now was to solve it. He attempted to win support from state governments, industry and hospital management by arguing that state costs for aged medical care under present law could become "fantastic," that unless there is a change labor will bring "overwhelming pressure" on management to give health insurance to retired workers, and that hospitals will have to assume the burden of more charity cases and attempt to put an "unconscionable" charge on self-paying middle-income classes.

Mr. Ribicoff used the sounding board of the witness chair to renew his series of accusations against the American Medical Association — nothing new in them.

American Hospital Association's testimony — with Frank S. Groner, A.H.A. president, as spokesman — was interesting. It indicated that, while A.H.A. was standing with A.M.A. in official opposition to the bill, the hospital men and the doctors were not quite seeing eye-to-eye on the issue.

For one thing, Secretary Ribicoff had stated and Mr. Groner did not deny that A.H.A. had worked closely with the Administration in drafting the bill. For another, Mr. Groner spent more time in suggesting changes in the legislation than in pointing out why it should not be passed. He made an all-out appeal for Blue Cross administration of the program, should it be enacted, in these words:

"There is an existing means for attainment of the goal of state level administration, namely, the Blue Cross Plans. These plans have established firm relationships with hospitals. They have trained staffs. They have demonstrated competency and efficiency and there are plans in

every state. This is the only agency at the state level that is competent and experienced in programs such as those proposed in this legislation. . . . The use of Blue Cross Plans would make it unnecesssary for the federal government to duplicate services and organizations which are already available."

A.M.A.'s president, Dr. Leonard Larson of Bismarck, N.D., was its principal witness. His formal statement was relatively brief, but he turned over to the committee a formidable 91 page document, which was a comprehensive study of the issues of aged medical care. It had ample documentary evidence to support the association's well-known reasons for opposing the legislation. A.M.A.'s principal concern, according to Dr. Larson, is that this or similar legislation "would retard rather than promote the science and art of medicine and the betterment of public health."

Dr. Larson argued that the Kerr-Mills act for medical care of the aged, passed last year, was being rapidly implemented by the states, "despite an organized, concerted campaign to interfere with its success." He said sponsors of the social security plan want the Kerr-Mills program to fail.

When Rep. Cecil King (D.-Calif.) diverted the discussion to A.M.A.'s over-all policies — particularly alleged pressure to bring individual doctors "into line" with association policy — Rep. John R. Byrnes (R.-Wis.) interrupted to say it was about time to stop trying the A.M.A. and to get on with an examination of the bill.

In general, testimony followed what is now a monotonous pattern — opposing the bill, spokesmen for state and national medical associations, chambers of commerce, insurance interests, business and industrial organizations, some farm groups; favoring it, spokesmen for labor, welfare organizations, nurses.

LEGISLATION FOR CONTROL OF DRUGS:

While the American Hospital Association stood up with the A.M.A., although not militantly, in opposition to the Kennedy plan for medical care for the aged, it pulled far away from the doctors on another critical issue — new drug legislation.

Testifying early in July before Sen. Estes Kefauver's antitrust and monopoly subcommittee, witnesses for the A.M.A. heard the chairman charge the association with dropping its advertising standards to obtain more drug revenue for the *A.M.A. Journal* and other publications. They answered all accusations.

The doctor witnesses, however, concentrated their testimony on attacking one provision of the Kefauver bill — a requirement that the Food and Drug Administration take over responsibility for determining the efficacy as well as the safety of a new prescription drug before allowing it to be marketed. The real efficacy of a drug, the doctor witnesses maintained, cannot be really established until after doctors in private practice have observed its effects on thousands of patients over many years. They said that under the bill, F.D.A. could rule a drug off the market and deny its use to the vast majority of the medical profession.

Although invited to testify before the Kefauver subcommittee, the American Hospital Association did not do so. Instead it filed a statement later. On the issue on which it came to a clear break with the A.M.A., the A.H.A. statement first explained that F.D.A. already has the right to rule on the efficacy of a drug when the safety of a drug cannot be properly appraised without considering its usefulness — that is, a situation in which a virtually useless drug might be prescribed for a critically ill patient, thus depriving the patient of the benefits of an existing valuable drug.

The statement then goes on to say:

"The bill would have the salutary effect of barring worthless drugs from being placed on the market. At the present time the only way in which F.D.A. can deal with worthless drugs is through court proceedings after the drug has been distributed. While these may be successful ultimately, they are often time consuming, cumbersome and expensive. The proposed amendment would avoid these problems by empowering the F.D.A. to require proof, when a new drug application is filed, that the drug will do what its labeling says it will do."

A.H.A. approved some of the bill's provisions for wider and more orderly dissemination of drug information to physicians, but questioned the desirability of general distribution of a list of dangerous drugs, because "the lay public is not capable of assessing information dealing with toxicity and harmful effects of complex drugs. The effect might be to mislead rather than to inform."

The hospital association also supported the bill's requirement that all antibiotics be batch certified by Food and Drug Administration, and that new drug patents be denied unless the drug produces new pharmacological effects. The statement said that such a system would do much to improve the efficiency of hospital formularies.

The letter to the subcommittee, signed by Kenneth Williamson as head of A.H.A.'s Washington office, said the association favors Senator Kefauver's proposal for licensing of producers of prescription drugs, unless it is determined that a broader and more effective inspection system alone would be sufficient.

On this, the letter observes:

"If a licensing system with comprehensive criteria for the applicant, and the penalty of revocation, were adopted, hospitals . . . would have the assurance that drugs were produced under conditions that ensured their integrity and efficacy." These safeguards, A.H.A. believes, would facilitate operation of hospital formularies and make possible greater savings in drug purchases.

In its discussion of licensing, the statement brushes against a long-standing controversial issue in the hospital fields — whether hospital administrators should be put under license. On this it declares:

"We support the necessity of licensing in the health field both for individuals and for institutions engaged in providing health services. Physicians and hospitals are licensed under state law if they meet minimum standards. The problems of drug production and distribution are nationwide in scope, and do not lend themselves to solution at the state level."

Asked if this constituted endorsement of licensing of hospital administrators, Mr. Williamson said A.H.A. "has never opposed" such licensing, but that its endorsement was "not the intention" of this part of the statement. He added, however, that he "supposed" the statement could be taken to include administrators as among those who should be licensed. Minnesota now is the only state that licenses administrators.

The Modern Hospital
SEPTEMBER 1961

Somers Report

Social Scientist-Economist Team Forecasts Brave New Institutionalized Medical World

NOT since Don Quixote set out across the Manchean plains to revive knight errantry has man been as conspicuously anachronistic as the solo-practicing general practitioner often is in today's highly institutionalized medical world. Carrying the Free Choice lance and wearing the Sacred Doctor-Patient shield, Don GP has been fighting with his back to the operating room wall, fending off specialists, hospital administrators, trustees, medical educators, accreditation authorities, social workers, health insurers, legislators and government officials. In years past, his shrill cries of "Corporate Practice!" "Lay Interference!" and "Socialized Medicine!" have always brought his fellow caballeros charging to the rescue, waving their Whereases on high. Recently, however, there have been signs that the rallying cry of the faithful may be losing its mystique: The call of "Fee for Service!" no longer evokes only shouts of approval; sometimes there are threatening answers like "Group Practice," "Closed Panel" and even an occasional, daring "Social Security." It has been reported, in fact, that hostile Knights of the Third Party have infiltrated that King Arthur's Court of GPiety, the A.M.A. House of Delegates.

Actually, the world in which the GP finds himself is not so much unfriendly as just different from what it used to be. While he was busy memorizing the functions of the autonomic nervous system, the world was changing: Medical practice was moving from the office and home into the hospital; surgical privileges were increasingly reserved for surgeons; trustees, administrators and nurses were learning that the medical degree and the halo are not indivisible; hospitals were accepting small monthly payments from the well rather than huge deficit payments from the sick; doctors were doing the same thing, in groups instead of singly; unions were building hospitals and paying some doctors salaries; community leaders and legislators were beginning to insist that hospitals across the street from each other shouldn't both have idle $30,000 cobalt machines; accreditation boards were demanding tissue reports and other evidence of professional evaluation; utilization committees were being formed to keep patients out of the hospital until they needed in and get them out when they wanted out; patients were sometimes asking questions, and even venturing opinions, in the Presence; old people were getting older and apparently sicker all the time and the government was getting ready to do something about them; and, finally, there were some medical associations acknowledging that medicine has some problems that can *not* be solved by Public Relations maneuvers.

These and other changes in the medical world are charted, analyzed and documented, in formidable detail, in a report published recently by the Brookings Institution following a three-year study financed by the Institution and the Ford Foundation and described by the investigators as covering "the organization, distribution and financing of personal health services and goods."*

A husband-wife team who are, respectively, social scientist and labor economist, the authors in their preface express the hope that the report may be useful to doctors, hospital administrators, prepayment and insurance executives, administrators of health and welfare programs, labor and management negotiators and trustees, and government officials with responsibility in the medical care field. It will be. Indeed, it is hard to see how these and any others professing literacy in the field of medical economics can get along henceforward without it. Here is the complete record of where they are, how they got there, and which way they are headed, organizationally and fiscally speaking.

Some of them, and especially, perhaps, some physicians and medical society officials, will be surprised to find themselves where the Somers have put them, and some will not be pleased to find out where they're going — straight down the road, say the Somers, to more accreditation, more regulation, more planning, more

*Doctors, Patients, and Health Insurance. The Organization and Financing of Medical Care, by Herman Miles Somers and Anne Ramsay Somers. Cloth. Pages 576. Price $7.50. Washington, D.C.: The Brookings Institution, 1961.

prepayment, more group practice, more hospital domination, more specialization, more generic name prescribing, more government support, and more patients who talk back. Here, for example, are some typical Somers findings and forecasts:

Hospital-Physician Relations.

The inescapable requirements of the modern hospital make it unlikely that the specialty societies (radiology, pathology and anesthesiology) will have their own way. In time, they will probably have less support from other doctors, not only because of increasing resentment of their exceptionally high incomes but also because of a realization that the kind of public explosion which could develop from such pressures could ultimately have repercussions on the privileged role of all doctors in relation to hospitals.

Regional Planning and Control.

The question is whether (hospitals) will be permitted to continue in relatively extravagant autonomy or whether, as they consume an increasing portion of public and personal budgets, the public will insist upon coordination in one way or another.

Prescription Drugs.

The key to . . . success . . . appears to be a formulary—made up and administered by responsible doctors—which provides a limited number of products, avoids duplication and prescribing by brand name. . . . Hospitals, institutions, public programs, and other organized medical care plans should be permitted to adopt formularies for their own staff or doctors serving them.

Progressive Patient Care.

The purpose was to achieve a more rational organization of facilities, services and staff and hence provide better quality care more economically. The opposition to progressive patient care is hard to pin down. . . . Despite the generally approving attitude of the A.M.A., many medical staffs are clearly suspicious, if not hostile.

Supply of Physicians.

The magnitude of the problem appears to require a major push along several parallel lines—more doctors, more paramedical personnel, more mechanical equipment, more rational organization, and more money.

Patient-Physician Relationship.

. . . If today's critics are correct, it can only be concluded that the image of the "traditional" doctor-patient relationship is not only inaccurate, but that it has lost most of its beneficent value and may now have become injurious to doctor and patient alike.

Organization of Hospital Employes.

Union organization among nonprofessional employes increased in 1959 and 1960. Despite their exemption from collective bargaining laws, it is difficult to see how the resistance of eastern voluntary hospitals can be sustained in the present American climate.

Blue Cross.

With its strong hospital ties Blue Cross is still the dominant factor in hospital insurance in the United States. Whether it can maintain this role in the face of ever-increasing competition and financial difficulties is one of the major issues in private health insurance today. Blue Cross finds itself increasingly pressured from many directions. On the one hand, many large group purchasers and state insurance commissioners facing repeated requests for rate increases are prodding Blue Cross to assume responsibility for consumer interests in relation to hospital practices affecting costs. On the other side, the A.H.A., local hospitals, the behind-the-scenes influence of the A.M.A. and public inertia all reinforce its historical role as fiscal agent of the hospitals.

Government and Private Health Insurance.

The inventive possibilities of the insurance mechanism are vast —so long as its hands are not arbitrarily tied by the assumption that each individual must pay in precise proportion to the risk he presents. To the extent that government helps to provide coverage for the small minority that private insurance alone may not be able to reach, it will improve the latter's chances of success in its far larger domain and help to assure that the insurance mechanism remains the primary method of financing medical care in the United States. In our pluralistic economy health insurance will probably never be expected to cover the full costs of illness. It will also probably be necessary for the predominant pattern of private insurance to be supplemented by limited forms of public insurance and public assistance.

Utilization Committees.

The task of identifying unjustified hospital admissions, overstays, or overuse of hospital equipment is very complex. Nevertheless the present cost of hospital care and the prospects of continuing increases make it essential that some checks on the reasonableness of use be devised.

Health Care of the Aged.

The assumption by government of responsibility for the poorer risks—with which private insurance cannot profitably cope to the public's satisfaction—could liberate the industry to meet successfully the challenge to survival in the much larger area of those under 65. As between . . . federal-state subsidy of private insurance for the aged and . . . including health insurance for the aged within the existing OASDI system, the latter appears simpler, more economical, and more equitable as well as involving less governmental intrusion in the affairs of private carriers, and greater dignity for the beneficiaries.

Group Practice.

The advantages of an institutional setting, group practice, and comprehensive insurance are readily apparent. However, it must be added that if the doctor-population ratio is permitted to fall much further, even all these aids to efficiency and thoroughness may not prove sufficient to maintain good doctor-patient relations for large portions of the population.

These and other conclusions and opinions make it probable that the embattled solo practitioner will view the Somers report primarily as a new arrow for the enemy's bow. However, while it is certainly unlikely that the Somers will receive accolades from the American Academy of General Practice, or, in fact, the A.M.A., the individual practitioner is by no means completely banished from their brave new institutionalized medical world. His survival is a matter of footwork, as they see it. When the patient becomes responsible instead of passive, the doctor must be humanistic instead of authoritarian; to keep his license, the practitioner must drop his lance and pick up a book. He might be well advised to begin with the Somers report. ■

Entrepreneurs looking for profits can start a proprietary hospital just about anywhere, and about all planners can do is wring their hands

Survey shows

Proprietary Hospitals Are Hard To Handle

Toothless licensing laws make it hard to stop construction of unneeded or low-standard proprietary hospitals, a Modern Hospital survey indicates.

The survey showed that in approving new hospital construction, many state licensure acts ignore the need factor and type of ownership. Instead, they rely on fixed construction standards that often (but not always) are minimal or outdated.

Thus, an entrepreneur looking for profits can build a proprietary hospital virtually anywhere zoning laws permit. All he has to do, in 14 of 15 representative states surveyed, is scrape by applicable statutes and obtain a permit to operate. Hospital councils and planning commissions can wring their hands, call the governor, argue, cajole, whisper, shout, plead, beg and complain — but no one really has to listen. *(Continued on Next Page)*

TAX LAWS AFFECT TYPE OF HOSPITAL OWNERSHIP

(*Continued From Preceding Page*)

In Massachusetts, however, hospital sponsors have to pay attention.

Here state laws are firm and rigidly applied. Massachusetts law specifies that no hospital can be "built, opened, converted or sold" without prior approval by the Division of Hospital Facilities and its advisory committee. This committee, by law, must include trustees and administrators of health care institutions — two of whom must be recommended by the Massachusetts Hospital Association, a requirement that gives voluntary hospitals a loud voice.

The Massachusetts Division of Hospital Facilities also moves vigorously when established hospitals fail to meet its standards. On several occasions it has initiated legal action to close such institutions. Not coincidentally, no new proprietary general hospitals have opened here in 10 years.

In neighboring *Connecticut*, it is difficult if not impossible to make big profits and still meet high state licensing requirements, which follow closely those of the Joint Commission on Accreditation of Hospitals. In that state there are only two short-term proprietary hospitals, both of which existed before the existing state licensing law was enacted.

Elsewhere, proprietary hospitals have an easier time getting started.

In *Illinois*, a licensing act concerned only with the physical aspects of hospital construction gives planning officials a "frail defense" in discouraging unneeded or minimal standard institutions, according to Dr. Karl S. Klicka, executive director of the Hospital Planning Council for Metropolitan Chicago.

The planning council, he explains, finds it fairly easy to control the development of voluntary, nonprofit hospitals. It has had a rough time, though, handling proposals for proprietary institutions. Unlike proprietary hospitals, voluntary hospitals rely on public contributions, foundation grants and federal funds, which are usually accompanied by built-in controls, regulations and careful scrutiny by objective agencies. Moreover, Dr. Klicka points out, sponsors of nonprofit projects in the Chicago area can be influenced by findings developed by the council from a set of operating principles. These findings help determine if the new hospital — or expansion of an old hospital — is in the best interests of the community. Most proprietary hospital sponsors are unmoved by these principles, Dr. Klicka has found, and on occasion ignore them when the findings are unfavorable.

In the last two years, for example, 14 proprietary hospitals have been proposed in the Chicago metropolitan area. After investigation, none was endorsed by the council. The hospitals were discouraged, Dr. Klicka indicates, for such reasons as inadequate planning, improper leadership, or lack of demonstrated community need.

One of the 14 hospitals — 110 bed, physician-owned Bruni Memorial Hospital in North Lake, a western suburb of Chicago — is under construction in spite of the planning council's active opposition. The hospital, Dr. Klicka says, is in an area already well supplied with beds and is being built by a physician who reportedly has been unable to obtain full surgical privileges in Chicago's voluntary hospitals.

Another proprietary hospital causing anguish in a western suburb is a 250 bed establishment under construction in Morton Grove. Here a new nursing home was being converted into a for-profit hospital although the additional beds are not needed, in the judgment of the planning council. This hospital, it turned out, was one of three planned by a man who was an associate of crime syndicate hoodlums and a "former strip tease joint impresario," according to Chicago newspapers and the local crime commission.

Construction approached the midpoint before it was halted by screeching headlines, stormy public hearings, and the state public health director, who pointed out that under state law the building could be approved later if a registered Illinois architect prepared satisfactory plans and a zoning variation was granted by Morton Grove.

Shaken by these experiences, Dr. Klicka fears it will be necessary to protect the community from similar episodes by appropriate legislation.

Another Illinois official, however, is not sure new laws will help. Howard Cook, executive director of the Chicago Hospital Council, points out that slippery propositions often ease through the tightest of laws when steered by "individuals more interested in themselves than in the community." Motivation, not type of hospital, Mr. Cook argues, discloses a hospital's intent. "It takes no special prescience," he says, "to understand that if the motives of the hospital's sponsors are below par so will be its place in the community."

Although planners have had their anxious moments handling contemplated projects, the number of proprietary hospital beds has stayed fairly constant in metropolitan Chicago in recent years, as it has across the country. (See table on next page.) At present, the planning council reports there are 14 proprietary hospitals totaling 1003 beds, an increase of approximately 200 beds in the last two years. Six of these hospitals are general service institutions, three are specialty hospitals, and five are psychiatric institutions. Five of the hospitals are accredited.

Other areas find a new problem cropping up: one of recognition. Several states report it's becoming increasingly difficult to tell a proprietary hospital from a nonprofit hospital without a balance sheet. A new, tadpole-like organization, apparently spawned by the tax structure, has been observed in one form or another in Washington, Michigan, New Jersey, and California.

These organizations are described by John Bigelow, executive director, Washington State Hospital Association, as "traditional nonprofit hospital on one end and outright proprietary hospital on the other end. In between is a gray area where a specific determination of a hospital's status is made only when it applies for Hill-Burton funds, foundation grants, or tax exemptions."

Here is how it works in *Washington*:

A hospital is operated by a corpo-

ration that is legally a nonprofit charitable organization, but is actually purchasing the hospital from a promotional organization that is for-profit on one end and nonprofit on the other.

For example, Mr. Bigelow cites one firm that so far has built two suburban hospitals. "One corporation built the hospitals for a second corporation. The second corporation sold stock to the public, door to door, and in various promotional ways. A third corporation operates the hospital as a nonprofit institution after purchasing the hospital from the second corporation. The same principals are involved in all three corporations," he adds.

The overriding issue here, that goes beyond tax exemption problems, is the effect these institutions have on the public. In Mr. Bigelow's view, it's all to the bad. "These technicalities," he believes, "are confusing to the public and tend to undermine the bona fide nonprofit hospitals' prestige."

In *Michigan*, where similar quasi-nonprofit hospitals are appearing, some nonprofit institutions rent buildings and land from profit making corporations. Usually, but not invariably, the corporations have a remarkably similar board of directors.

In *California*, and especially Southern California, where they are as popular as drive-ins, and perhaps more profitable, proprietary hospitals are a tender subject. Hospital groups are working hard to provide some measure of control, but any hospital that meets the requirements of the state hospital licensing act can still build anywhere regardless of type of ownership or service provided.

In *New Jersey*, the number of proprietary hospitals has dropped, but a lot of activity is reported from a New York contracting firm, helped by an "investment" firm, which sells hospitals to doctors in suburban areas with huge population growth.

So far, the state licensing bureau has had inquiries from representatives of five groups in four different locations — all with plans to build 425 bed hospitals at an estimated cost of $9 million each. While few

Proprietary Hospitals 1956 and 1960*: Fewer Hospitals, More Beds

	1956		1960	
	No. of Proprietary Hospitals	No. of Beds	No. of Proprietary Hospitals	No. of Beds
Alabama	76	2661	63	2422
Alaska	0	0	0	0
Arizona	11	378	17	601
Arkansas	51	1299	44	1157
California	211	9528	239	12,242
Coloredo	17	1513	12	1509
Connecticut	16	816	17	1250
Delaware	3	53	0	0
District of Columbia	4	295	4	386
Florida	60	2011	62	2349
Georgia	75	2325	58	2017
Hawaii	10	465	7	344
Idaho	12	295	8	183
Illinois	50	2906	39	2193
Indiana	20	737	16	630
Iowa	33	1055	23	920
Kansas	29	705	19	523
Kentucky	37	1682	35	1449
Louisiana	94	2589	95	2714
Maine	22	771	19	712
Maryland	13	629	11	599
Massachusetts	47	2704	43	2870
Michigan	48	1435	35	1549
Minnesota	38	983	18	461
Mississippi	43	1120	34	1047
Missouri	77	2838	68	2670
Montana	7	240	5	151
Nebraska	37	1008	29	801
Nevada	2	83	3	145
New Hampshire	4	135	2	95
New Jersey	22	1544	15	1067
New Mexico	13	243	7	175
New York	117	8875	118	10,106
North Carolina	39	1574	31	1515
North Dakota	7	165	7	178
Ohio	21	1265	20	1348
Oklahoma	73	2161	69	2054
Oregon	26	1306	19	1081
Pennsylvania	61	3302	55	3464
Rhode Island	3	77	3	79
South Carolina	27	753	19	504
South Dakota	8	125	6	107
Tennessee	90	2381	88	2761
Texas	326	9092	313	9372
Utah	5	110	5	100
Vermont	6	108	3	69
Virginia	43	2500	36	5639
Washington	38	1648	28	1075
West Virginia	41	2559	36	2207
Wisconsin	27	884	17	714
Wyoming	8	138	3	79
Totals	2148	84,069	1923	87,683

*From The Modern Hospital Directory of Hospitals, 1956 and 1960 issues.

believe that these hospitals will grow beyond the talking stage, one local governing board has already granted a variance on a 5 acre plot on which four local doctors plan to build a 72 bed hospital.

New York City **reports a sharp decline in the number of proprietary hospitals since 1945, but an increase in total number of such beds.**

The figures:

January 1956 – 53 hospitals; 3636 beds

July 1961 – 41 hospitals; 4929 beds

Four new proprietary hospitals are also under way here; these will add 880 beds to the 4929 in use in an area aggregating 63,534 beds.

Although voluntary hospitals deal with a state agency, proprietary hospitals in New York City are licensed by the city department of hospitals. The department's standards, one official feels, "are rather minimal and in some ways less stringent than those applied to voluntary hospitals by the State Department of Social Welfare." There are indications, he finds, that the city department will soon take a sterner position. For one thing, Associated Hospital Service of New York (Blue Cross) recently announced that all hospitals must be accredited within three years if they are to obtain full reimbursement. This, it is expected, will either raise the standards of marginal proprietary hospitals or encourage them to close.

In some states, notably Pennsylvania, it's easier to build a for-profit hospital than a nonprofit hospital

In *Texas*, the number of proprietary hospitals is decreasing in less populated areas but increasing in metropolitan areas. Hospital officials there are more worried at present, however, about continued pressure from nursing homes that desire to be licensed as hospitals.

In *Pennsylvania*, curiously, it is much easier to build a for-profit hospital than a nonprofit hospital – but there has been no evidence of growth of proprietary hospitals. Nonprofit hospitals here require a charter from the courts, which in turn require a certificate of community need from the state department of welfare; no such details obstruct potential builders of proprietary hospitals.

Other states report that the number of proprietary hospitals is either shrinking or stabilizing, but in any case is causing no furor.

In *Maryland* and the *District of Columbia*, the number of proprietary hospital beds continues to stay small; in *Delaware* there no longer are any.

The number of proprietary hospitals in *Florida* also remains constant, although authorities report at least four new ones are now under construction.

In *Ohio*, the number of such hospitals is decreasing; hospital officials, however, indicate they would be more comfortable if positive legislation were developed.

It was plain from the survey of these 15 states that voluntary hospital officials tend to distrust proprietary hospitals and their underlying profit motive. Their sour attitude stems from a belief that such institutions pattern their rates, but not their service, after nonprofit hospitals. Proprietary hospitals, they feel, keep profit ratios high and performance quotients low by eliminating teaching programs and research, skimping on emergency and obstetrical service, and ignoring charity or bad debt patients. This, they argue, shifts the burden of these expenses more heavily on nonprofit hospitals, which must adjust their rates accordingly.

"The growth of proprietary hospitals threatens the continued independence of voluntary hospitals," warns Robert M. Sigmond, executive director, Hospital Council of Western Pennsylvania. "Hospital care is a community affair. Voluntary hospitals can be strong enough to fulfill their community objectives only by serving the entire community, including provision of comprehensive services to the nonindigent patient."

While many health field officials probably agree with this, even more would admit that proprietary hospitals may provide excellent care and badly needed services in some areas, especially in new communities where voluntary funds are not quickly available.

"I'm not at all hostile to proprietary hospitals," explains one health field official, summarizing the feelings of most. "Only the bad ones." ■

These specific procedures help avoid failures in emergency room service

What It Takes To Provide Good Emergency Room Care

Jacob Horowitz, M.D.

IN MANY hospitals, the emergency room serves as the port of entry for all patients. After being seen there, a patient may be sent home, referred to the outpatient department, referred to his private physician, or admitted to the hospital. What happens to him in the emergency room, how he and those who accompany are treated, inevitably color his judgment of the hospital.

Failures in emergency room service may stem from many causes, but, in general, they can be traced to one or more of the following six errors:

- Lack of mature judgment with regard to the situation at hand.
- Providing too much treatment. In the case of many seriously ill patients it is obvious that they must be admitted to the hospital at once. Extensive laboratory and x-ray workups, which can and should be better ordered after admission, delay proper care and are deleterious to the patient.
- Providing too little treatment for the patient who is to be sent home or transferred to another hospital.
- Failure to inform the referring private physician of the patient's problem and illness.
- Failure to follow the recommendations of the private physician.
- Failure to explain to the family or friends of the patient why they have to wait, *i.e.* because of laboratory or x-ray reports or consultations.

In general, treatment in the emergency room service should be limited to urgent therapy. The most critical and acute cases must be attended to first and must have priority over nonemergent cases at all times. However, no patient should be sent out without having been seen by a physician.

For private patients, the measures dictated by good medical practice and judgment should be carried out until the arrival of the private physician.

For patients who have no private physician, I will attempt to outline certain procedures which have been developed by the medical staff and the administration of our hospital.[1]

(Continued on Page 90)

Dr. Horowitz is medical director, Department of Correction, New York City.

[1]Most of the material presented here derives from the orientation and operation of the emergency room service of a municipal hospital with a medical school affiliation.

As a General Rule, Refer Diagnostic Problems to Medical Service

The medical resident should be consulted with regard to the diagnosis, therapy and disposition of any medical case whose illness is obscure.

In addition to the usual medical illnesses, diseases included in the responsibility of the medical service are those of the central nervous system (exclusive of head trauma), gastro-intestinal hemorrhage from any cause, poisonings and renal disease, exclusive of obstructive uropathy. Diseases of the vascular system will ordinarily be considered the responsibility of the service providing definitive therapy. Diagnostic problems of any nature are usually referred to the medical service.

In the case of medical illness associated with primary surgical, gynecological or obstetrical conditions, the medical resident is expected to participate in their care.

Where immediate drug therapy seems indicated, caution should be exercised with the following drugs which are sometimes dangerously misused:

Morphine and other narcotics or sedatives, especially where chronic pulmonary insufficiency, central nervous system disease, or hypotension are present.

Picrotoxin and other analeptics. The indication for the use of these drugs in barbiturate overdose has not been established.

Cardiac glycosides if doubt exists as to prior use.

Chemotherapeutic agents and antibodies. These should not be administered without bacteriologic control, especially in obscure febrile disease or in patients with chronic valvular heart disease.

Intravenous infusions. Specific need should be present.

Consult With Orthopedic Resident Before Ordering Any Treatment

All patients with orthopedic emergencies should be seen and examined by the emergency room physician on duty.

The emergency room physician must consult with the orthopedic resident before any medications or treatments are ordered.

The emergency room physician should proceed with treatment in cases of extreme emergency such as arterial hemorrhage, shock or chest complications.

The emergency room physician should assist in all diagnostic and therapeutic procedures for all patients who are managed on an outpatient basis.

Require Consultation on Doubtful Gynecological or OB Cases

The minimum examination of patients in normal labor should include blood pressure, fetal heart rate, frequency of contractions, cervical dilatation, and station of presenting part as determined by rectal examination.

Patients who are beyond the twentieth week of gestation and are bleeding vaginally should have an immediate hemoglobin determination and their blood must be typed and cross-matched. These patients should not have vaginal or rectal examinations done in the emergency room but should be admitted immediately to the obstetrical service.

The obstetrical resident should be called immediately upon admission of a pregnant patient who has any of the following complications of pregnancy: vaginal bleeding, prolapsed cord, or preeclampsia.

Patients with ruptured membranes should be admitted immediately whether or not they are in labor.

Pregnant patients who may deliver before reaching the obstetrical unit should be accompanied by an intern. The house physician on service should be notified of such an admission.

If there is doubt as to whether a patient is in labor a consultation should be called.

Gynecological Service

Excessive pelvic examination should be avoided. The resident should be called as soon as the initial examination has been completed.

All patients with palpable pelvic masses should be seen by the resident.

All acute emergencies, such as patients with a ruptured ectopic pregnancy or other condition which might require immediate surgery, should have a hemoglobin or hematocrit and urinalysis of a catheterized specimen; the blood should be typed and cross-matched.

Take History and Physical Examination on Every Mental Patient

A history and physical should be made on all patients. It is impossible to evaluate any psychiatric patient without these. Then the resident in psychiatry should be called.

If the patient is comatose or unable to talk, it is important for the emergency room physician who first sees the patient to obtain as adequate a history as is possible from the family, friends, police, ambulance attendants, or whoever brought the patient to the hospital. These informants should be interviewed and the information recorded, since by the time the patient is seen by a psychiatrist the informants may no longer be available.

The management of delirium tremens and of withdrawal symptoms secondary to narcotic addiction are primarily medical problems and should be so treated.

Every patient, regardless of age or diagnosis, who is suspected of having attempted suicide should be seen by the resident in psychiatry prior to being released from the emergency room. This includes patients who are discharged to the care of a private physician. Patients have been known to commit suicide en route from the hospital to the doctor's office. If the patient is in need of acute medical or surgical treatment, or if he is comatose, the psychiatric consultation can wait until the patient is out of immediate danger or is conscious and able to speak.

Start Lifesaving Measures for Surgical Patients, Notify Resident

Emergency patients are in critical condition and the surgical resident should be called immediately. In the meantime, all necessary lifesaving measures should be instituted as indicated.

The emergency room physician should start the preliminary workup on acute cases and then notify the surgical resident.

Chronic disease patients should be seen and referred to the appropriate surgical clinic.

Suture Room Procedure

The objective in this area is to promote sterile technic and uniform procedures for cleansing and suturing wounds.

The suture room should be used only for clean wounds and new burns. Patients with old or infected wounds or burns and patients who need an incision and drainage of an abscess should be treated in a separate area.

The door to the suture room should be closed at all times except for passage to and from the area.

Masks are required for all personnel, patients, parents (in cases of injured children), and others (*i.e.* police officers, newspapermen and so on). Masks must be discarded after

each use and must not be worn when leaving the suture room.

When all the facilities of the suture room are in use, the decision as to where to place other patients with lacerations must be made by the professional personnel on duty.

Wound Preparation

Gross cleaning of wounds is a procedure which should be done by the nurses. They should first ascertain that the patient is properly restrained before beginning the procedure. All clothing must be removed from the immediate area of the wound. The wound should be washed with either green soap or hexachlorophene soap and water. If possible this should be done under running water. If this is not possible, the wound may be soaked for not longer than 20 minutes, after which it should be irrigated with clean water or saline solution; then a dry, sterile dressing should be applied. A shaved area of at least one inch around the wound should be provided. Profusely bleeding wounds should not be cleaned unless a physician is in attendance. In such cases, a dry sterile pressure dressing should be applied and the physician should be summoned immediately.

Physician Should Attend When Profusely Bleeding Wound Is Being Cleaned

Preparation for suturing. The nursing personnel should set up the preparation tray and cover it with a sterile drape until the physician is ready to use it. This tray should contain:

1 pair gloves
1 sterile towel
1 Kelly hemostat
1 syringe
1 large basin or 1000 cc. pitcher
1 small basin
1 medicine glass
applicators and 3 by 3 sponges.

The nurse should add one tablespoon of green soap to the small basin and fill it with sterile water or saline. She should pour 500 cc. of sterile saline into the large basin or pitcher and pour 15 cc. of tincture of benzalkonium chloride into the medicine glass.

The physician should scrub his hands with hexachlorophene soap; dry them with the sterile towel from the preparation tray; put on the gloves, and clean the wound as follows:

1. Scrub the wound with soap solution.
2. Irrigate the wound with saline before applying the tincture of benzalkonium chloride (since this is inactivated by soap).
3. If the physician elects to clean the wound with hydrogen peroxide, he must be sure to irrigate the area after using the hydrogen peroxide.
4. Apply the tincture of benzalkonium chloride to the area.

Suture Setup

The suture setup includes:

2 mosquito forceps
1 toothed forceps
1 scissors
1 5 cc. syringe
1 knife handle
1 needle holder
3 needles of varying sizes
3 by 3 sponges
1 drape

In preparing the suture setup, knife blade and suture material should be added as requested by the physician. Gloves should be set out in size requested by the physician. Nurse should assist the physician as requested.

Cleanup Procedures

Before the patient leaves the suture room, the nurse should clean all body areas of blood and/or excretions. Grossly soiled or wet clothing is to be removed and arrangements made for clean, dry clothing.

All dirty linen should be carefully sorted and searched for instruments, then placed in the dirty linen hamper.

Used knife blades, suture needles, and sponges are to be discarded.

The preparation tray, complete with basins, hemostats, medicine glass, and syringe should be placed in the central supply pickup area. All linen should be removed from this tray.

Syringes and needles and any other instruments which came originally with the suture setup should be placed in the designated central supply pickup area. Extra forceps or hemostats should be washed and placed in the appropriate suture room location to be sterilized.

The suture room area should be prepared for the next patient; all blood spattered areas should be washed and clean linen should be placed on the examining table.

Keep Accurate Records To Prevent Medico-Legal Complications

An often neglected aspect of the emergency room is the medico-legal implication of this service. Since many of the injuries seen here are the results of trauma, it is not uncommon for these patients to be involved in litigation at some future date.

It is therefore important that a chart with the appropriate entries be initiated for each patient no matter how minor the injury or how small the procedure. The chart notes should be brief and precise and should include a history, physical examination, diagnosis, disposition and progress notes of all the measures which have been undertaken on behalf of the patient. Of course, it is essential that the necessary authorizations for treatment be obtained. Where this is not possible because of the condition of the patient, the emergency room physician should go ahead with those procedures which are lifesaving. In all other cases he should consult the administration before proceeding.

There are many aspects of emergency service which I have not covered, *i.e.* physical facilities, layout, personnel, handling of compensation cases, poisonings and disaster plan operation. These areas are too individualized to be discussed generally and must therefore be evaluated by each hospital separately. A helpful tool for such an evaluation of a hospital's emergency room service is the check list prepared by the New Jersey Regional Committee on Trauma of the American College of Surgeons.[2] ■

[2]Surgeons To Study Emergency Service. Mod. Hosp. 90:67 (April) 1958.

Surgical Do's and Dont's in Emergency Room

— Establish airway.
— Treat shock promptly.
— Do not move patients in shock to x-ray department or to another hospital.
— Do not sedate patients who are under observation for abdominal injury or disease.
— Start fluids for dehydration.
— Do not start I.V.'s or cut-down on leg veins unless absolutely necessary.
— Use large bore needles for I.V.'s (*i.e.* 15 gauge).
— Make complete blood count and urinalysis on all candidates for surgery before they go to the operating room. Do these procedures early along with other necessary laboratory work.
— Have competent personnel watch for shock patients who are seriously injured and are removed to x-ray. Responsibility of the emergency room physician for the patient ends only when the patient is finally in his hospital room bed.

All patient rooms open onto these private outdoor patios, which encourage complete relaxation during stay. While the patios are protected from visitor traffic, they permit the patients to visit with one another.



Maternity Wing Babies the Whole Family

Relatives, friends and even small children can see the babies at Donald N. Sharp Memorial Hospital from outside to maintain protection from infection

DESIGN throughout the maternity wing of Donald N. Sharp Memorial Community Hospital, San Diego, Calif., reflects the old-fashioned belief that birth is an experience that can be shared in part by all members of a family, but the dangers of infection are not overlooked.

The three major divisions — labor-delivery rooms, the nursery suite, and patient rooms — all center around the main nurses' station located at the core of these three divisions, yet each is essentially separate. Each division has its own lounges and lockers, satellite nurses' stations, and supply rooms. This was planned to eliminate all but deliberate cross-traffic between the divisions and the resultant possibility of cross-infection. In addition, the entire traffic flow within the wing is planned to allow only a minimum of traffic between divisions and none at all between patients and visitors until after delivery and recovery. (*Text Continued on Page* 96)

All nurseries are separated by glass partitions for maximum service and security. This also makes it possible to see entire length of unit from any position inside.



Maternity wing has main entrance for public and a separate admitting entrance, shown at the right.





Children's playground near outside viewing windows allows the whole family to enjoy the visit.

Labor Rooms That Are Well Isolated From Traffic,

Yet Provide for Visits From Patients' Husbands, Are

One Feature of the Sharp Hospital Maternity Wing



Main nurses' station, at the core of the three major divisions, is located so as to control traffic from the labor rooms to the delivery area, and from the delivery area to recovery rooms and to the infant nurseries.

The twofold aim of the maternity wing of Donald N. Sharp Hospital is well illustrated by the arrangement of the labor rooms. The nine labor rooms are immediately adjacent to the patients' entrance, on each side of a work corridor isolated from all public traffic. A second corridor for husbands only extends along the three perimeter sides and provides access to any of the individual labor rooms.

The result is to isolate the staff from public traffic for the most efficient operation and prevention of possible contamination without limiting the visiting privileges of husbands while their wives are in labor.

Perhaps the outstanding family feature, Frank R. McDougall, administrator of the hospital, believes, is an exterior window wall through which relatives, friends and even children can view the babies in the nurseries without danger of infecting them.

The nursery has been designed with a central examining and workroom between each eight-bassinet nursery, to allow grouping of all babies born on the same day. This makes it possible to close down each nursery unit for a cleaning and holding period when the babies have been discharged.

The maternity wing, which is almost completely separate from the main hospital, was designed by Frank L. Hope & Associates, San Diego. ■



Patient rooms employ colorful draperies and wallpaper for a more homelike appearance. Sliding glass door shown in background opens onto patio. Shown is one of the four-bed rooms. Semiprivate rooms are similar.

Priority Plan Determines Who Operates When

This priority system for scheduling nonemergent admissions for surgery helps determine objectively which doctors' patients should be added to crowded operating room schedules during peak periods

John W. Prout, M.D., and Don A. Corey

UPON recommendation of the executive committee of the medical board, the board of trustees has approved a priority system for scheduling elective, nonemergent, surgical, gynecological, pediatric and medical admissions." This quotation is from the minutes of a board of trustees meeting of the Niagara Falls Memorial Hospital. The action, which was taken some time ago, brought good news to many medical staff members. Its application brought dismay to some physicians.

The priority system described here has proved its value, in at least one hospital, as an equitable solution for two long-standing problems. First, how does the hospital administrator motivate medical staff members to provide the self-government and self-improvement which they quite properly insist can be accomplished by no one else, but in which they are sometimes lax? Second, how can a sometimes inadequate number of operating facilities be fairly apportioned among the doctors during peak patient loads?

Real difficulty can be encountered when several surgeons with nonemergent patients are scrambling to get on an almost filled operating schedule. A closed-staff hospital, whether it is governmental, voluntary or proprietary, probably would not have this same problem. Certainly, the suggested remedies in this article would most adequately apply to the community hospital in which most or all of the local physicians have privileges.

No hospital can offer adequate service to the community it serves without a solid, well defined organization that includes its medical staff. This is basic and it is specifically required for accreditation by the Joint Commission on Accreditation of Hospitals. The only persons able to supervise and administer the activities of the medical staff are the doctors themselves, and to accomplish this requires time and

hard work on the part of many individuals.

The staff of most hospitals elects, or the board of trustees may appoint, a chief of staff and the heads of clinical departments and divisions. These physicians are directly responsible for the quality of medicine practiced in their various specialties and in the hospital as a whole. A number of committees must be appointed to provide a means for concentrated endeavor in many of the varied interests and responsibilities of a medical staff.

One committee which is relatively new, at least insofar as the frequency with which it is now found in hospitals, deserves special consideration. It is the medical audit committee, which is far more than a periodic check of professional service.

Self-Audit Has Advantages

Students of hospital administration are familiar with the various methods employed to fulfill the known or suspected need for audit. Most outside audits made by firms available for such service, or a team of recognized experts from a medical center, cannot provide some of the advantages of self-audit.

A medical staff organized to audit its own work can provide monthly results that allow for constructive action every month. Every hospital is unique by reason of the type of patients treated, the community environment, and local customs and traditions, and no one is more familiar with its particular needs than the local physicians. Probably the greatest disadvantage in self-audit is that it requires considerable effort from the already busy doctors and it demands unwavering leadership if it is to be what an audit should be — a continuing method of upgrading the medical care rendered.

This emphasizes the importance of providing motivation for doctors to take an active part in affairs of the medical staff. There are some normal events in the operation of a hospital that afford a perfect opportunity to influence staff members to attend committee meetings and willingly accept assignments.

Patients' needs for elective medical or surgical hospital service fluctuate continually and sometimes drastically. The result may be a severe strain on facilities at certain times. Usually it is impossible to provide facilities that will always meet peak demands. If this is the case there will be occasions when the operating room supervisor and admitting officer are forced to say "No, Doctor, we are booked to capacity." In effect this constitutes rationing, which must be done fairly and equitably.

Priority Gives Unbiased 'No'

The entire purpose of the priority system is to provide an objective and unbiased means for these people to determine when, and to whom, the "no" should be given. It should eliminate accusations of personal favoritism and it should remove some of the uncomfortable pressure placed upon these supervisors. The priority system is also a means of recognition for the doctors who are working for the betterment of the medical staff and hospital.

The determination of priority is actually a rather simple mathematical procedure whereby points are awarded commensurate with individual activity. The aggregate of points for a doctor compared with totals for the others will determine his position in the priority listing. Point values for positions held and work done should be based on the requirements in any given hospital situation. However, the

PHYSICIANS BY POINTS EARNED

Jan. 1, 1960-June 30, 1960

PHYSICIAN'S NAME	TOTAL POINTS	PRIORITY
D	55	A
B	52	A
P	52	A
I	51	A
K	48	A
Q	44	A
S	38	B
T	35	B
H	32	B
J	31	B
E	29	B
G	26	B
L	22	C
W	17	C
F	17	C
X	15	C
R	11	C
C	4	C
N	4	C
A	1	D
M	1	D
O	1	D
U	1	D
V	1	D

Fig. 2 — When points are awarded for activity, doctors' names are arranged chronologically by total points and arbitrarily divided into four priority groups. Priority groups D and C have seven and five names respectively instead of six and six. Ground rules required Dr. N's name to be placed in priority group C because his total points equaled the total for the sixth name included in priority group C.

For this system to work, attendance at meetings must be recorded and reported accurately

following list of point values may serve as an illustration.

Chief of staff	7 points
Vice chief of staff	6 points
Chief of department	6 points
Associate chief of department	5 points
Head of division	5 points
Committee chairman	4 points
Committee member	2 points
Each committee meeting attended	2 points
Active staff member	5 points
Consulting staff member	4 points
Courtesy staff member	1 point
Honorary staff member	A priority

It is apparent that the recording of points earned by staff members for attendance at meetings is important to prevent errors. This is not difficult, but since there may be 10 committees made up of as many as 50 different doctors close attention must be given. Each meeting attended by a committee member represents two points when calculation is made semiannually. To avoid misunderstanding, the doctors may be required to sign the attendance record in lieu of using the terms "absent" and "present."

Experience has indicated that priority groups should be calculated semiannually (see Fig. 1). This prevents anyone from riding along on past performance and it allows prompt recognition of accomplishment. The records of appointments and attendance must be kept accurately to substantiate all calculations. The doctors will be vitally interested in their priority positions and a detailed accounting should be available upon request.

What does the priority system offer the doctors? Depending on the individual hospital's situation, a limit of three weeks might be set as the period for which elective surgery may be scheduled in advance. The scheduling would have to be within the physical limits of operating room facilities, surgical nursing personnel, and surgical beds. Assuming that the demand is greater than the availabil-

Committee Activity Helps Determine Priority Ratings

ACTIVITY SUMMARY
Jan. 1, 1960 — June 30, 1960

NAME of PHYSICIAN	STAFF	OFFICE	COMMITTEES: EXECUTIVE	JOINT CONFERENCE	MEDICAL QUALIFICATIONS	OB-GYN QUALIFICATIONS	SURGICAL QUALIFICATIONS	MEDICAL CONSULTATION	SURGICAL CONSULTATION	PEDIATRIC CONSULTATION	OBSTETRICAL CONSULTATION	EMERGENCY DEPT. AUDIT	MEDICAL AUDIT	SURGICAL AUDIT	PEDIATRIC AUDIT	OBSTETRICAL AUDIT	INTERN	LIBRARY	PHARMACY	RADIOACTIVE MATERIALS	INFECTION	TOTAL POINTS
A	1																					1
B	5	5	12/2			4/2					6/2					12/2						52
C	4																					4
D	5	6	12/2	12/2					2/2					19/2								55
E	5												12/2						8/2			29
F	5															10/2						17
G	5	5													8/2					4/2		26
H	5	5												8/2	10/2							32
I	5	6	10/2		8/2					4/2			8/2								2	51
J	5							6/2					10/2								4/2	31
K	5	5	10/2					4/2					10/2				4/4					48
L	5	5										10/2										22

Fig. 1. — This partial sample summary sheet shows the results of six months of activity by doctor. In the committee columns the first figure represents the number of committee meetings attended times 2 (value assigned) and the second figure is the value assigned for being a committee member (2) or a committee chairman (4).

ity, which is one reason for the priority in the first place, the following priority system could be installed.

Priority A — May schedule elective surgery up to three weeks in advance.

Priority B — May schedule elective surgery on Thursday and Friday up to three weeks in advance. On other weekdays elective surgery may be scheduled up to two weeks in advance.

Priority C — May schedule elective surgery up to two weeks in advance.

Priority D — May schedule elective surgery on Thursday and Friday up to two weeks in advance. On other weekdays surgery may be scheduled up to one week in advance.

Assuming that four priority groups, as described, are adequate for the number of surgeons involved, the list, in proper sequence by total points awarded (see Fig. 2), may be divided into four equal parts. This should be an arbitrary division; if there are 24 surgeons each priority group should contain six surgeons. Suitable ground rules should cover such possibilities as having a number of surgeons that is not divisible by four or having more than one-quarter of the total number with the same number of earned points.

The advantage of the higher priority group, however determined, must have practical everyday value. If this is the case the surgeons most active in medical staff affairs will be rewarded by extra privileges, and, at the same time, the operating supervisor has a built-in procedure which relieves her of the necessity for judging each request for elective surgery on subjective factors.

The application of the priority system to medical beds is less complicated but equally effective. Whenever there are requests for admission of nonemergent patients which exceeds the available medical beds, advance reservations may be required as follows:

Priority A — Physicians shall have preference over priority groups B, C and D in admitting nonemergent patients.

Priority B — Physicians shall have preference over priority groups C and D in admitting nonemergent patients.

Priority C — Physicians shall have preference over priority group D in admitting nonemergent patients.

Whether priority applies to surgical facilities or medical beds, it is essential that the appropriate department chief play an active part in the application of the priority system. With the help and support of the hospital administration he must make certain that there is no deviation from the priority procedure. The importance of avoiding any sort of favoritism or danger of succumbing to a loud voice cannot be overemphasized. The proper advice to those surgeons who find it impossible to schedule is to suggest that they begin carrying their share of the load.

The number of doctors who will volunteer for committees and other assignments is nothing short of amazing.

This approach should not be interpreted as participation by force. Rather it should be considered, positively, as a method of giving practical recognition to those doctors who make a special effort to maintain medical and hospital patient care at the highest possible level. ■

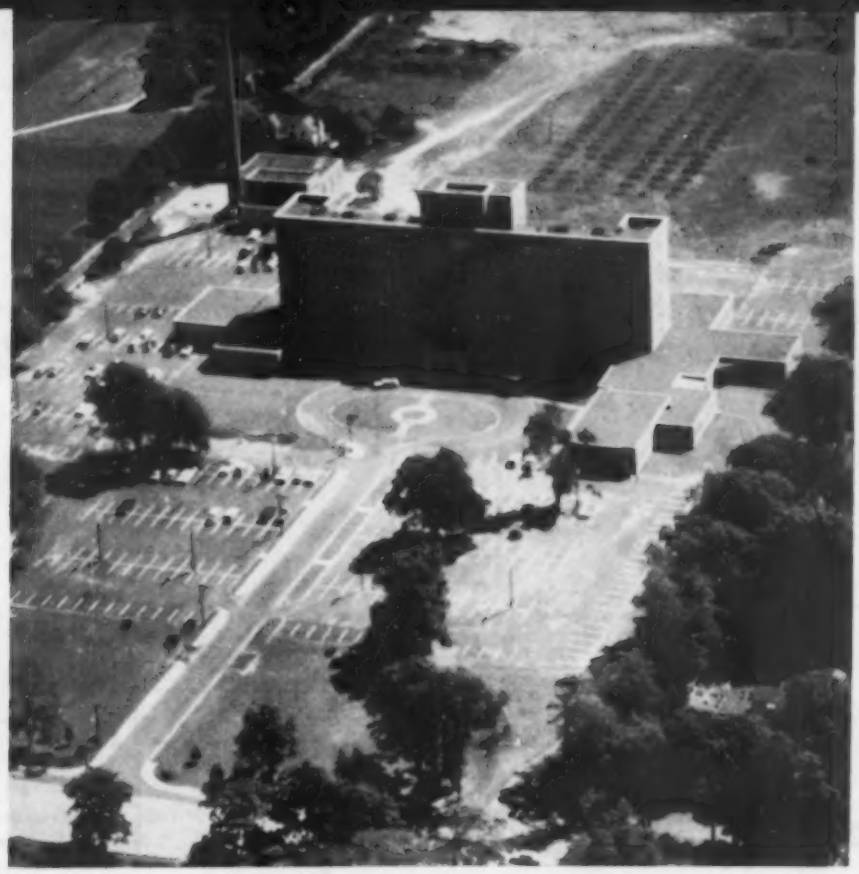


Dr. John W. Prout



Don A. Corey

Because improvement of hospital service is a joint responsibility of administration and medical staff, the associate director and the chief of surgery of Niagara Falls Memorial Hospital, Niagara Falls, N.Y., joined forces to describe the hospital's system of determining which physicians should have priority in admitting nonemergent patients during peak occupancy. This is not only equitable, the authors point out, but it has added merit of rewarding doctors who serve actively on staff committees and thus encourages them to do so. Mr. Corey, representing administration, has a master's degree in hospital administration from Columbia University and is a member of the American College of Hospital Administrators. Dr. Prout received his M.D. from Hahnemann Medical College and is a diplomate of the American Board of Surgery and a member of the American College of Surgeons.



Site of Good Samaritan Hospital provides ample space for the anticipated expansion.

The Modern Hospital of the Month

Services Stand Ready in Wings

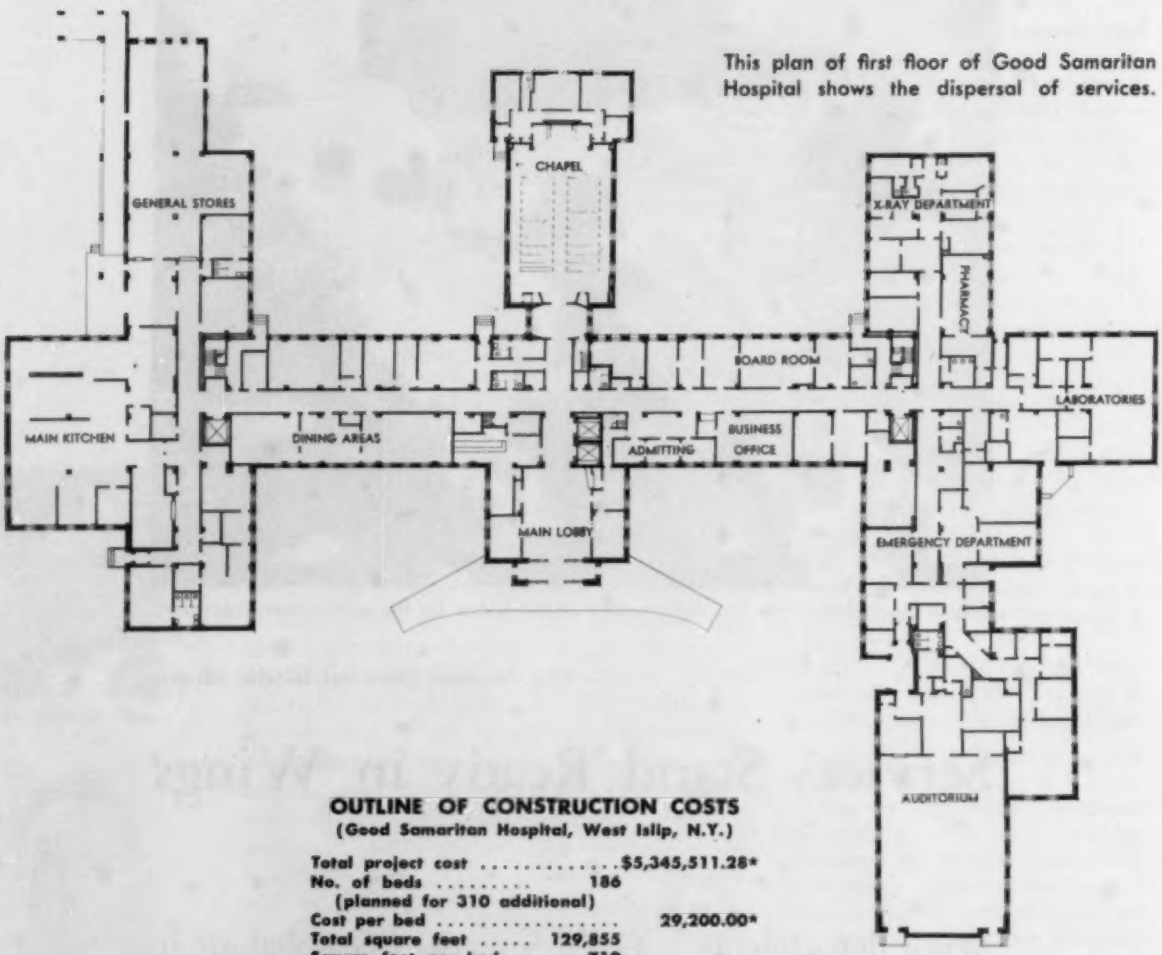
Major departments at Good Samaritan Hospital are in the wings to make expanding any or all of them easier

WHEN Good Samaritan Hospital, West Islip, L.I., N.Y., expands it can do so in all directions. Recognizing that centrally located services are often difficult to expand when it becomes necessary to increase the bed size, the architects have placed these service departments in separate wings, so that it is possible to extend any of them without interfering with the others.

Foundations and structural framing were included in the original construction to facilitate such expansion. Similarly, columns, foundations and mechanical and electrical services have been provided to allow for five additional stories.

Naturally, as the hospital officials explain, these construction details have added to the per bed and per foot cost of the present building, but are expected to provide substantial savings as the hospital grows. In addition, the main kitchen, boiler plant, and fan rooms are designed to serve the hospital when it grows from its present 182 beds to 330 beds, as planned.

While its design makes expansion easy, the architects, Crow, Lewis & Wick, New York, have not sacrificed present efficiency and convenience, as is shown in the plans, pictures and additional text on the next two pages.



This plan of first floor of Good Samaritan Hospital shows the dispersal of services.

OUTLINE OF CONSTRUCTION COSTS

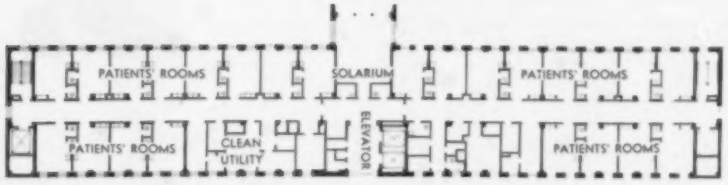
(Good Samaritan Hospital, West Islip, N.Y.)

Total project cost		$5,345,511.28*
No. of beds	186	
(planned for 310 additional)		
Cost per bed		29,200.00*
Total square feet	129,855	
Square feet per bed	710	
Cost per square foot		35.91
Total cubic feet	1,822,602	
Cubic feet per bed	10,000	
Cost per cubic foot		2.56

*Includes cost of Group I, II and III equipment and site preparation.

The hospital presented here has been selected as the Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital, the architects, and the state agency. A similar award will be made each month.

Triple-Cross Plan of First Floor at Good Samaritan Hospital Keeps Services Separate But Accessible



Patient rooms are located in the central core of the building, on single corridor nursing unit plan shown.

Location of most major departments on the first floor, while it made expansion easy, presented the problem of how to relate the major departments there to each other and to the nursing, surgery and obstetrical departments on other floors.

Good Samaritan's solution — a long triple-cross plan — drew special comment from one consultant. He pointed out that "by dispersing the four elevators, these departments are brought within convenient reach of the nursing floors in the six-story rectangular block above them."

The wings on the first floor have been used for the main kitchen, radiology department, laboratory, storerooms and employe locker rooms.

The operating and obstetrical suites are on the sixth floor, but the planners anticipate that when the addition is built the obstetrical suite will be included at the maternity level, permitting expansion of the operating and sterile supply areas.

The site is only about 10 feet above sea level, making basement rooms impracticable. The boiler room and laundry are therefore located in a detached service building at the rear of the hospital, another praiseworthy idea mentioned by outside consultants.

Nursing units are small, 24 beds, and well arranged. Bedrooms are primarily semiprivate and each is provided with a toilet.

The planners' foresight is evident in many small details. For example, while wainscoting has been used extensively in the hospital, all door frames in plaster finish walls have been set out far enough to receive vinyl fabric wainscot, if and when it is installed. ■





Emergency lobby (top) opens directly onto fracture room, shown through doorway. Patient rooms are primarily semiprivate, as shown in lower picture.

When the hospital faces a bad news break it is important for the administrator to know what to do before the reporters come

How To Have a Good Press Under Pressure

Seymour Standish Jr.

MUCH has been written about good hospital press relations under circumstances that show the hospital as a haven for the sick and fountainhead of medical progress.

What about the instance, however, when the hospital finds itself in the middle of a news story that everyone wishes had never happened?

For example:

Your nursing supervisor has informed you that a patient has just gone out the fifth floor window. The suicide was successful. The coroner is on his way. The woman was a member of your auxiliary board.

Or perhaps it was this one:

Your attorney calls. He has had definite word that a malpractice action is being filed. Your hospital is named, as well as the surgeon who did a tendon transplant on a little girl. The transplant, unfortunately, was on the wrong foot. It's a court suit, settlement having failed.

Or again:

The admitting department has just informed you that a very well known politician has been admitted. Admitting diagnosis, acute alcoholism. The family says no visitors, no publicity. But the papers have just called to ask if he is in your hospital.

You have a very short time to decide on a course of action. It's obvious that nobody is going to come out of these situations happy, least of all you. But here are a few rules you can follow that will make the interval right after you hang up the telephone the most productive.

Adapted from a paper delivered as part of a public relations panel, Association of Western Hospitals, San Francisco, 1961.

1. Decide what things are already inevitable

Don't waste your time or effort battling something that is going to take place regardless of what you do.

For example, a suicide is police news. The papers already know about it, or will within an hour. A suit to be tried in court is public news also. Dockets are scanned by courthouse reporters every day. The telephone call about the politician indicates his admission is no secret.

All three of these stories are already in reporters' hands, or soon will be.

2. Notify the patient's physician of what has happened

Tell him what has happened and what you plan to do. He probably will want to leave press responsibilities in your hands. But he should be filled in just as quickly as you can get him. If he says "keep it out of the papers," let him know this isn't possible, but that you *will* do everything possible to minimize the impact.

3. Make yourself personally available to the reporters

Let your switchboard and your secretary know that you expect and will handle press inquiries. Even though the reporter knows the suicide has



A lecturer in the department of preventive medicine, as well as assistant to the chairman of the board of health sciences at the University of Washington, Seymour Standish Jr. here lectures hospitals on how to prevent bad public relations when they are under fire from the press. Mr. Standish brings long experience in public relations to bear on his subject. He has been supervisor of informational services of the Washington State Department of Health, executive secretary of the Washington State Health Council, and director of public relations for the Washington-Alaska Blue Cross.

occurred, he will want more information. This is where your own area of judgment and discretion begins.

Get the full story from your staff, then relay the essential facts to the reporters promptly. If you have a public relations officer, you'll perhaps delegate this responsibility to him. The essentials are accuracy and promptness.

4. Be reasonable and cooperative with the reporter

He is interested in turning in a reasonable, factual account of what happened. Sensationalism is seldom a goal of today's newspaperman. If you are cooperative in furnishing a reasonable minimum of information, you will not be hounded. If you are evasive or unavailable, the reporter will try to get his information elsewhere.

5. Do your best by the patient

Of all three instances, the case of the fugitive politician is the most difficult. The suicide will be reported, but the story will run its course quickly. The court suit is essentially removed from your hospital – but the chances are great that it will not be covered in such detail as you fear. But the public figure who asks for privacy is a tougher problem. You will simply have to do your best. It would be futile to try to deny he has been admitted. On the other hand, you are not obliged or privileged to release diagnostic information.

The thing to remember is that if a man is a public figure, he is himself accustomed to dealing with the press. Or if he's incapacitated, his family or staff can readily understand the problem. Let them know that since the admission is known, something must be said. Work with them on the phrasing of a simple statement. Make this statement promptly available. If the person is sufficiently well known, work out a system with your staff and the attending physician for providing periodic condition reports to the newsmen.

6. Exercise a little perspective

You are hypersensitive to your own name, and the name of your hospital, in print. But this same name doesn't jump out of the page at everybody else the way it does at you. Remember the dozens or hundreds of times each year that stories appear indicating that you have promptly accepted and cared for an accident victim. You are known by your works in the community. And anybody in the hospital business has done enough good so that he – and his institution – can weather a rough sea now and then.

In summary, don't run from the reporter. Make yourself available. Give him promptly the information that's appropriate. And the chances are very good that it won't be as awful as you thought when the telephone first rang. ■

These Patients Help Themselves in Style

Self-care unit offers luxury at low rates to ambulatory patients and makes 80 beds available for those who need hospital care



Beds in all rooms make attractive and comfortable sofas or chaise lounges in the daytime. Easy chairs, color telephones, and television add to luxury.

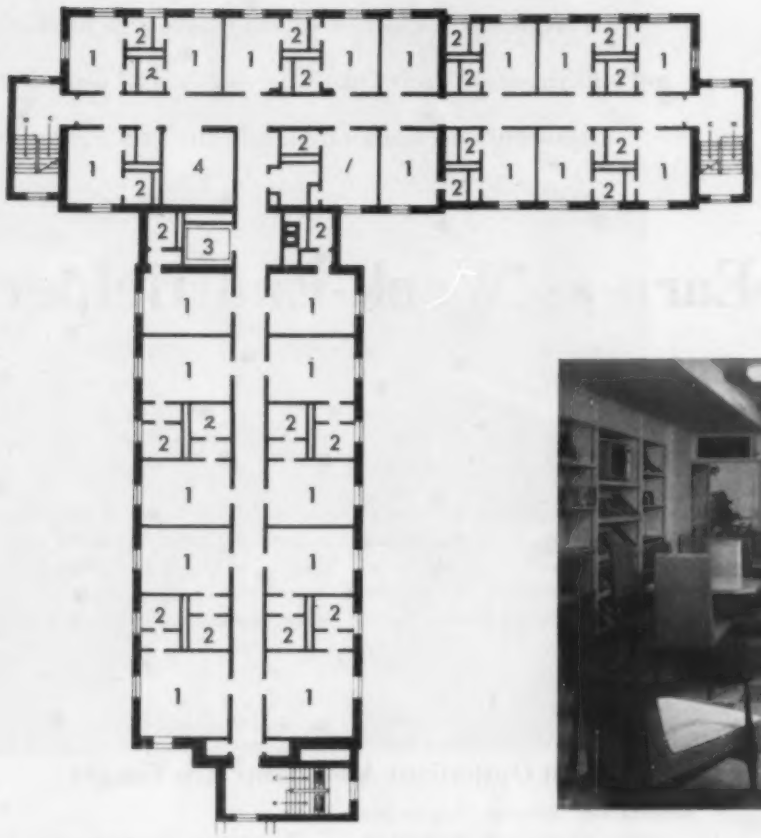
SELF-CARE is a pleasure, both esthetically and economically, for patients housed in the 80 room Progressive Care Center of North Carolina Baptist Hospital at Winston-Salem.

Opened last March, the Center was created to provide accommodations at reasonable cost for diagnostic and convalescent patients who do not need the services provided for a bed patient and to release hospital beds for patients who really need them, Robert Walker, administrative assistant of the hospital, explains. Nearly six months of operation have justified hospital officials' belief that the Center would fulfill both these purposes and also relieve a critical shortage of professional personnel.

The Progressive Care Center is housed in the former student nurses' residence which was transformed into a fireproof, air conditioned building with 80 rooms for patients plus auxiliary facilities designed for their comfort, convenience and pleasure. Each patient room is provided with extra sleeping accommodations for relatives or friends who wish to be with the patient, Mr. Walker reports.

As the photographs on these pages and the cover indicate, the unit looks as little like a hospital as possible. Rooms are colorful and each has a private bath and dressing room. Walls are paneled and wall-to-wall carpets cover the floors.

For all this the patients pay from $7 to $12 a day, depending on the room selected, Mr. Walker says. They also pay for their meals and, of course, for professional services and medications. Even so, Mr. Walker points out, they save from $10 to $12 a day every day they are housed in the Center, as compared to rates in the main hospital. ■



Minimal Care Facility

Second Floor

1. Patient's room
2. Bath
3. Elevator
4. Lounge

Plan of second floor of Progressive Care Center, North Carolina Baptist Hospital, is same as for third floor.



Recreation rooms provide games and reading materials, as well as a pleasant atmosphere for patients to socialize. Extensive use of pastel tints adds to the informality.



Each floor has a lounge, such as this one on second floor, where patients receive visitors.

High school boys with an interest in medicine get a glimpse of their future by serving as outpatient attendants on week ends, and they do a good job

Boys Learn, Earn as Week-End Helpers

Edmund J. McTernan

ON WINTER week ends at North Conway, N.H., many skiers whiz merrily down the eastern slope of the White Mountains — into a fracture bed at Memorial Hospital. Sometimes the pile-up reaches near disaster proportions of from 50 to 70 patients on a week end. Summer sports also bring their quota of accident victims.

This increased week-end workload is complicated by the facts that North Conway is in a relatively isolated region and that no additional trained personnel is available to assist the heavily burdened staff.

Our solution has been to train our own week-end helpers and the program has proved extremely successful. The helpers are junior and senior high school boys who have expressed an interest in a career in medicine and will benefit by being given a real insight into the career. Doctors, nurses, patients and the hospital also benefit by the assistance of intelligent and willing attendants who provide a high quality of service at relatively low cost.

Once the program had been decided upon at a series of conferences between the administration, nursing and operating room staff members, we got in touch with the guidance counselor of the local high school and offered employment to from two to four boys on recommendation of the school authorities. We specified that the boys chosen should have expressed interest in medicine or related fields or have interests that might eventually develop into a vocation for medicine. Most important, they had to be sufficiently mature, in the estimation of the guidance counselor, to accept the responsibilities and psychological impact of hospital work.

We offered to train them in the tasks to which they would be assigned and, in addition, give them as many opportunities as possible to learn some fundamentals of subjects relat-

Mr. McTernan is administrator, Memorial Hospital, North Conway, N.H.

What Outpatient Attendants Are Taught

Orientation: Welcome, tour of hospital, explanation of hospital organization.

Hospital Ethics: Chain of command, security of information, deportment toward patients, doctors, nurses, others.

Elements of Human Anatomy and Physiology: Tissues, organs, systems, most common diseases and injuries and their effect on the body.

Elements of Medical Terminology

Basic Principles of Aseptic Technic: Contamination and sterility, handling of supplies, elements of microbiology.

Basic Nursing Procedures (as taught to aides and orderlies):
- Bedmaking
- Admitting patients to unit
- Collection of routine specimens
- Assisting patients into bed, wheel chair, stretcher
- Helping patients to walk
- Assisting patients to eat and drink
- Transportation of patients in the hospital
- Elementary body mechanics — lifting, standing
- Enemas
- Preoperative skin preparation

Basic Nursing Procedures (taught to O.P.D. attendants only):
- Elements of first aid
- Removing patients from vehicles
- Transporting injured patients short distances; protection of injuries
- Carrying stretchers safely
- Undressing injured patients
- Assisting the doctor in examining injured patients
- Orientation to the area — location of supplies, equipment
- Stocking and restocking cabinets and carts
- Adjusting crutches to size
- Assisting in application of plaster casts
- Cleanup of instruments and supplies after use

Operating Room Procedures:
- Gowning and scrubbing for surgery
- Moving about in the operating room
- Assisting during surgery (*i.e.* holding limbs)
- Cleanup of operating rooms after surgery



Outpatient attendant practices aseptic transfer technics in the accident room under the nurse's supervision.

ing to medicine and to be exposed to factual information about careers in this field. (See accompanying chart.)

The enthusiasm and cooperation of school officials were remarkable. Arrangements were made for the hospital administrator and the director of nursing to visit the school and explain the program to interested students. Approximately 12 boys attended the meeting, after which appointments were made with nine who wanted to apply for the program. After consultation with the guidance director, the administrator selected the two boys with the highest recommendation and greatest apparent interest in medicine for the first trainee program.

We did not set a limit on the training period, our intent being to consider each individual a trainee until the supervisor felt he had gained sufficient mastery of each assignment. In practice, it has developed that the boys have seemed to gain competence in each of their duties after the equivalent of two weeks of full-time duty in addition to the initial full week of training.

Training began during the Christmas vacation week, with the administrator, director of nurses, and operating room supervisor (who is also in charge of the O.P.D.) participating. Both boys were on duty for the first week. Subsequently, they were assigned to duty in the department, with one boy being on duty each week-end day. Inservice training continued during the ensuing weeks under outpatient department nurses.

The attendants help receive and interview patients; undress and assist with male patients; transport patients within the hospital; maintain supply closets; assist staff doctors during application of casts; clean surgeries after use, and perform a variety of other tasks.

During their training period the boys were paid 85 cents an hour; when we considered them fully trained, their pay was raised to $1 per hour – the same as that of nurse's aides. They are responsible for providing and laundering their own uniforms. Of course, they are classed as employes and are therefore covered under our liability insurance.

No notable problems developed during the training period; nor have they since. We believe this is the happy result of great care in selecting the students, care we could not have exercised without the complete cooperation of the school guidance officer. The boys have worked well, they are liked by everyone, and we have not had a single complaint about them from any source.

Other persons, certainly, could have been obtained to fill the job these high school students are doing. But it would be hard to find other employes to match them in terms of enthusiasm and interest, which they have transmitted to other staff members. Doctors and nurses have been most willing to help the boys and to teach them as much as possible to keep their interest at a high level.

Commenting on our training program, George T. Davidson Jr., the guidance director, points out that frequently a boy manifests a desire to become a physician but has no real conception of what it means to be a doctor. Mr. Davidson agrees that the chance to work in the hospital outpatient department gives such a boy an excellent opportunity to see the doctor at work in real life situations and thus gives him a practical lesson in the field of medicine so that he can make a sound decision about his vocation.

On the basis of this experience, we plan to extend the program to additional students in the future. We now look to the high school as a potential source of many categories of employes and as a valuable co-worker in the community interest. ■

New Contract Signed in Milwaukee Between Hospital and Local 1572

MILWAUKEE. — Mount Sinai Hospital here has signed a new contract for nonprofessional employes with Local 1572 of the A.F.L.-C.I.O., American Federation of State, County and Municipal Employes.

Agreement on the contract, which will be in effect until Nov. 1, 1962, was reached "after two to three months of negotiation," according to Manuel Cohen, administrator of the hospital. "It's a reasonable contract for employes," said Mr. Cohen, "without being detrimental to the hospital or its purpose."

"One of the things we wanted to effect in the new contract," he told The MODERN HOSPITAL, "was to equalize some of the salaries we thought were uneven. This," he added, "we were able to do."

Under contract terms, reprinted in full below, hospital nonprofessional employes work a five-day, 40 hour week with time and one-half after eight hours a day or 40 hours a week. All work after the seventh consecutive day is paid for at time and one-half. Employes called to work on their regular days off are paid a flat $2 above any amount they otherwise earn.

The hospital also is required to pay a premium of 10 cents an hour on split shifts. Any employe who begins work after 10:30 in the evening gets a 5 cent hourly differential.

Vacations run 10 days after one year's service and 15 days after five years' service. Six paid holidays are recognized. Paid sick leave is allowed at the rate of one day for each month of service to a maximum of 45 days, and the hospital is required to provide Blue Cross and Blue Shield insurance for all employes who have been on the payroll for at least six months.

The contract also states that neither union nor employes shall participate in a strike against the hospital during the term of the agreement.

Here is the text of the agreement between the hospital and Local 1572, which for convenience is referred to as "the union" in the agreement:

Full Text of Agreement

Here Are Terms of Contract Between Mount Sinai and Local 1572, A.F.L.-C.I.O., in Milwaukee

ARTICLE I

Union Recognition.

Section 1. The Employer recognizes the Union as the exclusive bargaining agency for employes covered by this Agreement. This Agreement shall apply to the bargaining unit described in the Notice of Election issued by the Wisconsin Employment Relations Board concerning the voting in stipulated representation election conducted on Feb. 26, 1959.

Section 2. This Agreement shall cover all regular full-time employes and regular part-time employes in the classifications listed in the Wage Schedule attached.

Regular full-time employes are defined as those employes who work forty (40) hours or more per week. Regular part-time employes are defined as those employes who work twenty (20) hours or more per week, but less than forty (40) hours per week. The benefits of regular part-time employes shall be computed according to their regular scheduled number of hours of employment per week.

Section 3. The Union is the instrument of the hospital employes and was organized by them to serve their needs.

ARTICLE II

Union Membership and Notices.

Section 1. The Hospital will notify the Union no later than the tenth (10th) of the following month of all new hires and in the notification will provide the Union with name, classification, starting rate of pay, and residence address. They shall also, at this time, notify the Union of all reclassified employes and terminated employes.

Section 2. The Union agrees that it will admit to membership in the Union all present employes and all future employes hired or rehired by the Employer, who, under the terms of this Agreement, are represented by the Union and who are eligible to membership in the Union under its Constitution and By-Laws.

Union Security.

Section 3. Each new employe shall, as a condition of employment, within 31 calendar days of his employment, acquire and maintain membership in the Union. An extension of an additional 30 days may be made by mutual consent.

Section 4. The Employer agrees not to discriminate against any employe because of membership in the Union or because of any lawful activities on behalf of the Union, nor to discipline any employe for reporting matters pertaining to this Agreement to the Union; but nothing herein shall be deemed to permit Union activity during working hours. The Union agrees not to discriminate against any employe. (*Cont. on p.* 176)

Although credit granters shy away from bad risks and deadbeats, most of them still give credit to persons with delinquent hospital accounts

People Who Owe Hospitals Still Get Credit

Thomas R. Matherlee

A PERSON who owes money on a hospital bill is generally considered a much better credit risk than is the person who owes money elsewhere. At least the credit granters are more willing to take a chance with the person who has a delinquent hospital bill. This conclusion was reached after a series of interviews with 50 men who are affiliated with the consumer credit field in a wide spectrum of types and sizes of business and financial organizations.

The information in the chart on page 112 shows that 45 of the 50 businesses surveyed extend credit to persons who have a delinquent hospital account listed on their credit report; four do not, and one does not have any way of knowing whether the credit applicant has a delinquent account of any type. By the same measure, 32 of the 50 businesses also extend credit to persons who have a delinquent consumer goods account on their credit report; 17 do not, and one does not have any way of knowing whether the credit applicant has a delinquent account of any type because he does not utilize the credit bureau's services.

Moreover, 38 of the 50 businesses differentiate between delinquent hospital accounts and delinquent consumer goods accounts, and 12 do not. Of the 12, eight ignore both types and four do not extend credit at all if there is a delinquent account of any type on the credit report.

From these facts one can establish that the extension of credit appears to be a matter of degree. Factors taken into consideration are the age of the delinquent account; the amount of the delinquent account, both monetary and number of accounts; circumstances which caused the delinquent accounts; the amount of credit being applied for; whether the credit application is for the same type of product or merchandise that the delinquent account represents; the credit applicant's income level; the total amount of credit the applicant has with other businesses, and whether the applicant has had previous credit experience with the business being applied to.

A person can obtain credit with relative ease provided his over-all credit rating is not too low. Also, a credit granter is more willing to take a chance on the person who has delinquent hospital accounts than on the one who has delinquent consumer goods accounts. One real estate broker went so far as to say that even though a delinquent account of any type is supposed to be sufficient basis for a G.I., F.H.A., or other insured finance application to be rejected, certain agencies will approve the application even if there is a delinquent hospital account on the applicant's credit report.

Many of the persons interviewed stated that "morally speaking it is probably wrong to give delinquent hospital accounts less weight than other types of delinquent accounts." According to the findings of the survey it does not appear that many of the people who made the statement are too concerned with the morals of the case when it might mean a possible decrease in their sales. This is substantiated by the number of businesses that differentiate between the two categories of delinquent accounts and by the reasons given for differentiating.

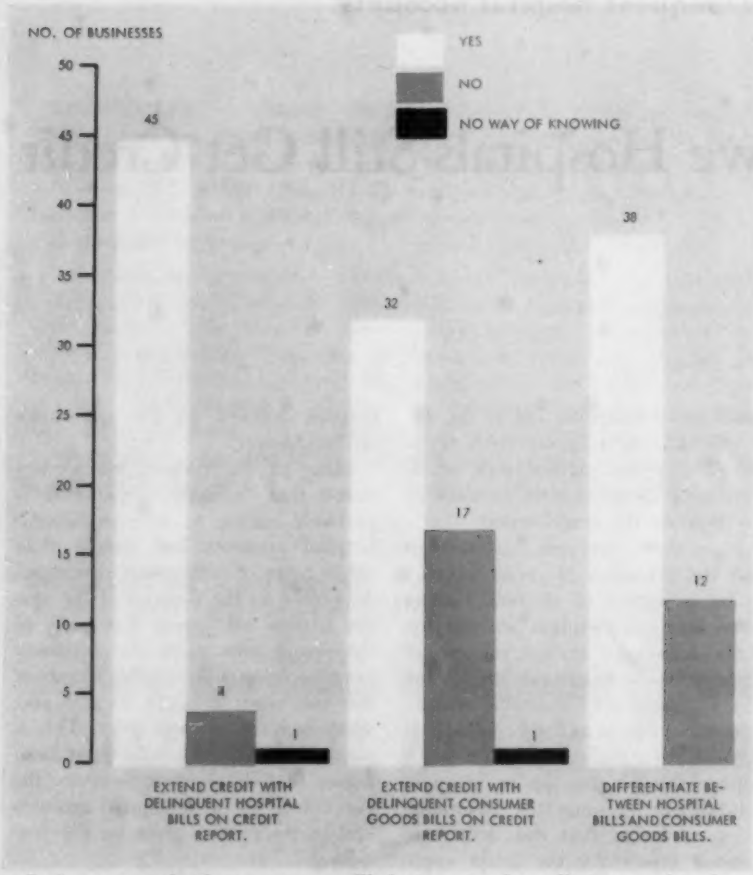
Are there any valid reasons for the differentiation between a delinquent hospital account and a delinquent consumer goods account when it comes to extending credit? The men interviewed in this survey, for the most part, attempt to justify the differentiation by a humanitarian philosophy or by the assumption that they would lose too much business by refusing to extend credit to persons who have delinquent hospital accounts listed on their credit report.

Some of these men gave several reasons for differentiating between the two types of accounts. The reasons are listed in the table presented on page 114.

The statement made most frequent-

Mr. Matherlee is assistant administrator, Richland Memorial Hospital, Olney, Ill. Condensed from the author's master's thesis prepared in partial fulfillment of the requirements for his master's degree in hospital administration at the University of Chicago.

SURVEY OF CREDIT PRACTICES OF 50 FIRMS



Business organizations are more likely to extend credit to people who have delinquent hospital bills on their credit report than they are to those who have been delinquent about paying for consumer goods, chart shows.

ly was, "So many people have delinquent hospital accounts."

Estimates ranging from 30 to 95 per cent of all credit applications were given. If these estimates are true, it is easy to understand the effect this would have upon the income of the businesses if they refused to extend credit to the people who have delinquent hospital accounts. One might argue, though, that if the percentage is as great as the interviewees estimated it to be hospitals would have to close their doors.

The second most frequently made statement was, "The cost of hospital care is too high."

Many of the interviewees stated that hospitals cannot justify their charges and that the average person cannot afford the expense of hospitalization, even with insurance coverage. These same people frequently admitted they knew little about what is involved in hospital operations and costs. Yet they were making accusations about hospitals as a whole without any sound reason.

Attitudes formulated because of an unfortunate personal experience with a hospital or because of "hearsay" were mentioned 18 times.

Although there were no apparent negative attitudes on the part of all the interviewees, as far as personal experience was concerned, the need for better public relations was mentioned frequently. Hospitals are apparently handicapped when it comes to public relations because they are service organizations. When a person considers making a purchase of consumer goods, he usually questions the vendor about the quality, style, benefits, price and so on of the item being considered. He usually does not form a negative opinion without a basis for doing so. The situation is not the same when it comes to hospitals or hospital services. Do not hospitals warrant the same interest and consideration that other businesses receive? Certainly most hospitals would welcome such interest.

Fourth on the list of reasons for differentiating between delinquent hospital accounts and those of other types was, "So many hospital accounts are disputed."

When asked why they thought so many hospital bills are contested the interviewees gave the following replies: Because hospitals perform a service and people can easily dispute the quality of the service. People often feel they are overcharged. People dislike paying for something they do not want. There are often misunderstandings as to whose responsibility

the hospital bill is. Hospitals frequently have a miscellaneous charge listed on the bill and people want to know what they are paying for. People do not understand the costs involved in the operation of a hospital. Many people do not feel morally obligated to pay for hospital care – they feel that the hospital should be a charitable organization. Many people do not know what their insurance policy will pay for and consequently they become indignant at the hospital when the coverage is not as great as they thought it would be. Finally, hospital credit and financial personnel do not take sufficient time to explain the bill to the patient.

What about the businesses which do not grant credit to the person who has a delinquent hospital account on his credit report? Why do they refuse credit to these people?

The four businesses which follow this policy gave the following reasons for their philosophy: "If a person will contest a hospital bill he will do the same with other bills," and, "I consider a delinquent hospital account in the same light as I do any other delinquent account because I have had the opportunity to exchange ideas and discuss mutual collection problems with hospital credit personnel." These four businesses were a bank, lumber company, retail pharmacy, and a gas home appliance store.

Here are 11 conclusions that can be drawn from this survey:

1. It is the weight given a delinquent consumer goods account which differentiates between it and a delinquent hospital account.
2. Most people feel that hospitals are morally obligated to care for a person regardless of the person's ability to pay.
3. Unfortunate personal experiences and unsubstantiated "hearsay" influence the formulation of negative attitudes toward hospitals.
4. When a decision must be made which will affect the income of a business, many people make the de-

HOW TO PERSUADE THE PUBLIC TO PAY ITS HOSPITAL BILLS

1. Take the lead through state hospital associations in getting the public interested enough to inquire into the services available in its hospitals. The method chosen will have to be something which public relations has not presented up to this time.
2. Take advantage of the credit organizations that are available. Attendance at credit organization meetings could lead to a cultivation of mutual understanding of hospital credit problems and consumer goods credit problems by representatives from both fields. Personal friendships can be developed which would have a positive reaction on attitudes. Work with the state credit associations. Attend the meetings sponsored by the state credit associations.
3. Hire qualified credit men as credit managers. The larger outlay in salary would certainly be justified by the larger collection percentage that would be realized.
4. Review admission, dismissal, credit and collection policies and procedures regularly.
5. Establish sound credit policies. Arrangements for credit must be definite and then proper follow-up should be given. Use tact!
6. Study the possibility of utilizing preadmission forms for all elective cases. By utilizing the information given in such a form the hospital can check further and establish the prospective patient's credit before he is admitted to the hospital.
7. Consider the feasibility of using credit cards, payment books, or charge accounts. Publicize the fact that credit arrangements are available. Check the possibilities of bank financing.
8. Be more cooperative with credit men in other fields. Work together through the credit reporting agency to take advantage of the efficiency of the system.
9. Take time to explain the bill to the patient.
10. Let the patients know that the hospital is more than happy to answer all their questions.
11. Be adventurous. Explore new methods and ideas.

cision that will increase the income regardless of any moralistic values that might be attached.

5. Many people know little about what is involved in the operation of a hospital. Neither do they understand the differences in types of hospitals, all hospitals being placed in the same category.

6. Most people do not realize that the great increase in hospital costs has been largely due to public pressure for luxuries and for higher quality care which can come only from expensive equipment, research and education, and by increasing the wage scale of hospital personnel to a level high enough to be in competition for the high quality person.

7. Many statements made by people for differentiating between delinquent hospital accounts and delinquent consumer goods accounts are excuses rather than valid reasons.

8. If a hospital finds itself in a predicament because of poor collections, it is partially because it is not taking advantage of the available tools for improving its relationship with the credit field and it is utilizing haphazard credit and collection methods.

9. As long as there is a competitive market, businesses will take chances on persons who have a questionable credit rating.

10. If a change in attitude toward delinquent hospital accounts is to be realized, it will come because hospitals and hospital associations that are progressive, willing to keep abreast of the American economy and credit methods, and working together have devised a method of getting the public as interested in what they are buying from a hospital as they are in what they are buying from other businesses. The job is simply too great for an uncoordinated effort on the part of individual hospitals.

11. If people investigated the services of their community hospitals as closely as they investigate a contemplated consumer goods purchase, hospitals would not have to wrestle with the public relations problem as much as they do at present. It appears that the public is using the "poor public relations" claim against hospitals when, in actuality, it is the public that is not taking advantage of the efforts of hospitals to improve them.

Although there may have been a positive change in attitudes toward hospital bills during the last decade, this survey has not shown any definite trend which would indicate a more considerate attitude by the consumer credit field.

The smaller businesses appear to be least stringent when it comes to credit requirements. The wariest businesses are those which market merchandise that cannot be repossessed, with the exception of home appliance stores. Four of the five surveyed businesses which sell only home appliances refuse credit to persons who have a delinquent consumer goods account of any type listed on their credit report, but only one would refuse credit to a person who has only a delinquent hospital account on his credit report.

Is there anything hospitals can do to improve the situation? Some of the persons interviewed think so.

Nineteen felt that there are things which can be done to improve the situation regarding delinquent hospital accounts through personal dealings between hospital credit managers and credit managers representing other businesses. Thirty-two felt that hospitals could benefit by a concerted educational effort directed toward the general public, and 25 stated that they would probably be more considerate of delinquent hospital accounts if they had more knowledge concerning them. ■

TABLE 1 — Why the Surveyed Businesses Differentiate Between Delinquent Hospital Accounts and Delinquent Consumer Goods Accounts

Statement	Times Stated
1. Sickness and hard times involved	10
2. High cost of hospital care	21
3. Insurance should have paid but did not	1
4. So many hospital accounts are contested or disputed	14
5. Hospital accounts are easy to beat	2
6. So many people have delinquent hospital accounts	37
7. People will pay a secured note when they will not pay on others, so the risk is less	3
8. A man obligates himself voluntarily for consumer goods, but he has no control over a hospital bill	4
9. Have had an unfortunate personal experience	17
10. Hospitals will not reciprocate credit information	1
11. Hospitals do not see that their own employes pay their debts and they are poor risks	1
12. Hospital bills are for a service rather than a tangible object	4
13. Hospitals "pad" bills with extra charges	3
14. Hospitals are supposed to be charitable	3
15. Profit making hospitals can stand the loss	2
16. Tradition of the enterprise	2
17. People have to wear clothes and eat	2
18. Poor public relations	4
19. Hospitals are too lenient	4
20. Poor administration in the hospital	1

Do Waiting Lists Reflect Need for Beds?

This three-month study disclosed what happens to the people who are on hospital waiting lists

Louis Block, Dr. P. H.

HOSPITALS frequently use the existence of waiting lists as an indication of the need for more facilities and the existence of pressures for beds.

The problem of waiting lists is confused by the fact that often no distinction is made between advance reservations and actual waiting lists for beds. Advance reservations can be defined as elective procedures, not of an emergency nature, which are scheduled at the convenience of the doctor, the patient, or the hospital. Waiting lists can be defined as procedures that must be done as early as possible, but which are not admitted at that time because of lack of facilities.

To understand the total backlog of existing pressures, both advance reservations and actual waiting lists must be studied. Although waiting lists, in themselves, may be an indication of pressures, advance reservations do not necessarily reflect pressures caused by lack of beds, but may be related to the pressures on or desires of the medical staff and even the patient himself.

To determine the relationships between advance reservations and waiting lists, a three-month study (August, September and October of 1960) was undertaken in four hospitals in a metropolitan area serving more than 500,000 people in a midwestern state.

Here are some of the findings:

1. The backlog of advance reservations remained fairly constant. It had a tendency, based on individual hospital observation, to be greatly reduced during the summer months and to expand rapidly in the fall. This may indicate that the hospitals could take care of a great part of the fall and winter buildup of reservations during this period.

2. Most advance reservations were surgical cases.

3. Approximately one in every 10 advance reservations was canceled for some reason.

4. Approximately 25 per cent of the total advance reservations were scheduled for some time beyond the study period. These can be considered carry-overs. (*Cont. on p.* 116)

Dr. Block is president, Louis Block and Associates, hospital consultants, Washington, D.C.

(*Continued From Page* 115)

5. Approximately three out of five reservations were admitted to the hospitals.

6. Waiting lists were about one-third as large as reservation lists.

7. Approximately 70 per cent of the waiting list was medical.

8. More than seven out of 10 persons on the waiting list were admitted; about one in seven was canceled. The remainder, about one in seven, was carried over beyond the study period.

9. The size of the waiting list remained fairly constant.

10. Fourteen per cent of the advance reservations were made for within one week of the time the request was called in; 29 per cent within two weeks; 46 per cent within one month; 61 per cent within two months, and 85 per cent within three months.

11. Virtually all of the advance reservations that were admitted to the hospital were admitted on the date of the reservation. This is indicative of the hospitals' ability to plan such service and to maintain such a schedule.

12. Advance reservations that are canceled are usually canceled prior to or on the date of the reservation. This means that hospitals are not left with empty beds as a result of "no shows."

13. Fifty-nine per cent of those on waiting lists were admitted or canceled within a week of the request.

14. Distribution of patients on the waiting lists by categories of service was as follows:

Of those admitted, 895, or 66.3 per cent were medical and 454, or 33.7 per cent were surgical.

Of those who canceled, 219, or 78.2 per cent, were medical and 61, or 21.8 per cent were surgical cases.

Of those remaining on waiting list as of Oct. 31, 1960, 204, or 81.3 per cent were medical and 47, or 18.7 per cent were surgical.

15. Although doctors generally have privileges at more than one hospital, they are reluctant to use those privileges at any other than their prime active privilege hospital, unless forced to do so. In this study area, seven out of 10 physicians had multiple hospital privileges, with the average of four privileges per physician. Almost three-fourths of these multiple privileges were courtesy, honorary or consulting.

It should be recognized that this analysis portrays a particular situation and points up the need to conduct specific studies in specific areas.

The accompanying table shows the extent and disposition of waiting lists in the four hospitals studied. ■

ANALYSIS OF WAITING LISTS, Aug. 1, 1960 — Oct. 31, 1960

	Medical		Surgical		Total	
	Number	per Cent	Number	per Cent	Number	per Cent
Number on waiting list as of July 31, 1960,	125	—	19	—	144	—
Added — August, September, October, 1960	1193	—	543	—	1736	—
Total	1318	—	562	—	1880	—
Time between date of request and action:						
Same day	88	6.7	60	10.7	148	7.9
1 day	179	13.6	74	13.2	253	13.5
2 days	127	9.6	63	11.2	190	10.1
3 days	102	7.7	64	11.4	166	8.8
4 days	97	7.4	63	11.2	160	8.5
5 days	67	5.1	22	3.9	89	4.7
6 days	39	2.9	21	3.7	60	3.2
7 days	33	2.5	18	3.2	51	2.7
0-7 days	732	55.5	385	68.5	1117	59.4
8-15 days	157	11.9	92	16.4	249	13.2
16-30 days	110	8.4	24	4.3	134	7.1
31-60 days	65	4.9	9	1.6	74	3.9
61-90 days	24	1.8	2	0.3	26	1.4
91 plus days	19	1.5	3	0.5	22	1.2
Unknown days	7	0.5	0	0.0	7	0.4
Total number admitted	895	67.9	454	80.8	1349	71.8
Number canceled	219	16.6	61	10.8	280	14.9
Number still on waiting list as of Oct. 31, 1960	204	15.5	47	8.4	251	13.3
Total	1318	100.0	562	100.0	1880	100.0

Analysis of the waiting lists at four hospitals for three-month period showed that 59.4 per cent of those on waiting list were admitted or had canceled within a week of the time of request for accommodations.

What Kind of Consent Forms Do Hospitals Need?

A general consent form authorizing the physician to perform any procedure he deems necessary is not sufficient to protect the hospital from liability. The integrated use of two forms described here establishes proof of the patient's consent

John F. Horty

THE best way in which a hospital or physician can prove that a patient authorized a medical or surgical procedure is to use a written consent form.



John F. Horty

It is true that an oral consent, if proved, is just as binding as a written one, for there is no legal requirement that a patient's consent be written. However, there are many judicial decisions indicating that an oral consent may be difficult to prove in court. It seems only common sense, therefore, that a hospital should not rely upon the oral consent of a patient unless there is no time to procure a written consent.

For a written consent to be effective it must be drafted so as to include all the elements of a valid consent. The form must then be signed and must show that the consenting person understood the nature and consequences of the procedure contemplated. Standard practice in many hospitals has been to use a consent form containing language general enough to permit the physician to perform any medical or surgical procedure which he thinks would be in the best interest of the patient. This form was generally signed by the patient as part of the admission procedure. Such a general consent form should not be used by a hospital.

While a consent form cast in general language enables the hospital or physician to contend that the consent authorized extension, alteration or modification of the procedure, it completely fails to show that the patient understood the original procedure, or had any real knowledge of the treatment being undertaken. It is entirely possible for the patient, after treatment, to claim he did not know that the doctor was going to do what he did, and it is possible that the jury will believe him. Forms should be used that retain the virtues of the general consent form, and yet provide against its serious defects.

The most satisfactory method for the hospital to establish proof that a patient consented to medical or surgical treatment requires the integrated use of two consent forms.

A consent to medical or surgical treatment, in fairly general language, should be signed upon the patient's admission to the hospital. This form records the patient's consent to the more routine hospital services and medical treatment. A signed special consent form should then be procured before any nonroutine surgical or medical procedures are undertaken. These two forms, utilized together, provide satisfactory protection to the hospital, its employes, and medical staff from any contention that the procedure was unauthorized.

The sample forms shown on page 118 were drafted to be as succinct as possible but, at the same time, to cover all the elements of a valid consent. It would have been possible to draft many other forms for special procedures and circumstances. However, in the interest of hospital operating efficiency, and because many of these forms are handled by relatively untrained personnel, it is logical to limit the number of forms as much as possible, so long as legal protection is not sacrificed. The special consent form illustrated here is adaptable to cover special procedures and circumstances, and it is recommended that this form be used whenever such circumstances arise.

Let us first consider the admission consent form. The admission consent form should be signed upon the patient's admission to the hospital as a routine part of the hospital admission procedure. However, its importance should be emphasized so that the patient is aware that he is signing a consent form, and the reason for obtaining his authorization should be explained to him. He should carefully read and understand the form before he signs it. The admission and

(*Text Continued on Page* 119)

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Separate Consent Forms Should Be Signed on Admission and Before Any Special Procedures

CONSENT UPON ADMISSION TO HOSPITAL AND MEDICAL TREATMENT

PATIENT: _____

DATE: _____ TIME: _____ A.M. P.M.

1. I, (or _____ for _____)

knowing that I (or _____) am (is) suffering from a condition requiring diagnosis and medical or surgical treatment do hereby voluntarily consent to such diagnostic procedures and hospital care and to such medical, surgical or x-ray treatment by

Dr. _____ his assistants or his designees

as is necessary in the judgment of Dr. _____.

2. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examination in the hospital.

3. I hereby authorize _____ Hospital to retain, preserve and use for scientific or teaching purposes, or dispose of at their convenience, any specimens or tissues taken from my body during my hospitalization.

4. This form has been fully explained to me and I certify that I understand its contents.

_____ _____
Witness Signature of patient

(If patient is unable to consent or is a minor, complete the following):

Patient (is a minor _____ years of age) is unable to consent because

_____

_____ _____
Witness Closest relative or legal guardian

These two consent forms are specific in their terms to protect the patient, yet provide enough latitude to allow for modern hospital and medical technics of patient care.

SPECIAL CONSENT TO OPERATION OR OTHER PROCEDURE

PATIENT: _____

DATE: _____ TIME _____ A.M. P.M.

1. I hereby authorize Dr. _____ and/or such assistants as may be selected by him, to perform the following procedure(s): _____
(List procedure(s)

on _____
(Name of patient) or (myself)

2. The procedure(s) listed in Paragraph 1 have been explained to me by Dr. _____ and I completely understand the nature and consequences of the procedure(s) to be as follows:

_____
(Designation of procedure(s) in terms of what will be done to the

_____
patient's body and what will be the consequences of the procedure(s).

3. I recognize that, during the course of the operation, unforseen conditions may necessitate additional or different procedures than those set forth in Paragraph 1. I therefore further authorize and request that the above named surgeon, his assistants, or his designees perform such procedures as are, in his professional judgment, necessary and desirable, including, but not limited to, procedures involving pathology and radiology. The authority granted under this Paragraph 3 shall extend to remedying conditions that are not known to Dr. _____ at the time the operation is commenced.

4. I consent to the administration of anesthesia to be applied by or under the direction and supervision of Dr. _____, and to the use of such anesthetics as he may deem advisable, with the exception of _____

5. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of the operation or procedure.

6. *Check One*:

_____ A. I hereby authorize the _____ Hospital to preserve for scientific or teaching purposes or for use in grafts upon living persons, or to otherwise dispose of the dismembered tissue, parts or organs resulting from the procedures authorized above.

_____ B. I will be fully responsible for making other disposition arrangements. Removal of the part from the hospital will be accomplished within 10 days after discharge; failure to remove before 10 days have passed will constitute approval of disposition by _____ Hospital under (A).

7. [☛ See ¶2-20 for language if procedure is an experimental one.]

_____ _____
Witness Signature of patient

(If patient is unable to sign or is a minor, complete the following):

Patient (is a minor _____ years of age) is unable to sign because

_____.

_____ _____
Witness (Closest relative or legal guardian)

SURGICAL CONSENT SHOULD BE MORE PRECISE THAN ADMISSION FORM

(*Continued From Page* 117)
special consent forms are designed to be used in conjunction with one another. They are not alternative forms.

There are certain instances in which the signing of the admission consent form might be dispensed with.

For most outpatient treatment the hospital may safely rely upon voluntary submission to show consent. However, this is a matter of hospital administrative policy. The signing of an admission consent form may also be dispensed with in certain other instances, such as when a woman already in labor presents herself at the hospital for the delivery of her child. Her action in coming to the hospital for care under such circumstances may be considered to be a voluntary submission to the medical and hospital routines usually associated with the delivery of the child, and no consent form is necessary. Dispensing with the necessity of signing a consent form is suggested in such a circumstance because the patient may be in such pain as to be actually unaware of what she is signing, thus making the consent ineffective. Also, when a patient is admitted in immediate need of medical care it is highly undesirable for the hospital to delay treatment while a consent form or other papers are signed.

It should be noted that the above exception to the general rule would not apply when a patient is admitted for delivery, but is not at that time in labor. When delivery is to be by means of cesarean section, or labor is to be artificially induced after admission, or when the patient requires other special procedures or anesthesia, the admission consent form should be signed upon the patient's admission to the hospital.

Let us examine the admission consent form paragraph by paragraph.

Paragraph 1. This form is designed to cover only hospital procedures which by their nature do not require the special consent form. The admission consent form would cover routine hospital care, laboratory procedures, most diagnostic examinations, most outpatient treatment, and the use of x-rays for diagnostic purposes. It also provides protection for routine procedures undertaken by any hospital personnel, the attending physician, or any other physician called into the case by the attending physician. It provides personal coverage for all persons who have legitimate reasons for touching or administering to the patient, protecting both the hospital and the physician.

The blank in the first paragraph is provided to permit the insertion of the name of whoever consents for the patient, if he is unable or legally incompetent to consent for himself. A blank is also provided to insert the name of the attending physician. If two or more physicians are attending the patient, the names of both physicians should be included. The use of the words "assistants or designees" permits substitution of a physician, where a substitution would not violate any contract between the patient and his physician.

Paragraph 2. Courts have uniformly held that a patient can recover, despite consent, if he is able to show that the physician guaranteed the success of the operation or treatment, and such operation or treatment was, in fact, not successful. This paragraph provides evidence that no such guarantee was made to the patient.

Paragraph 3. This paragraph permits the hospital to carry out normal procedures for the disposal of specimens or tissues taken from the patient or permits their preservation and use for both scientific and teaching purposes, at the hospital's option.

Paragraph 4. This paragraph indicates that the patient understood the nature and consequences of the procedures to which he is consenting, thus satisfying the requirement that the patient understand what he consents to.

Signature Block. Space is provided for signature by the patient, or for signature of someone authorized to consent for the patient. Questions of who can consent in lieu of the patient will be discussed in a later article. It should be noted that space is also provided for the signature of a witness. Although the consent is legal without a witness, a witness can provide proof of the genuineness of the patient's signature, and of his competency to sign the form. One witness is sufficient.

The admission consent form is designed to prove authorization only for routine hospital care. It is most important, therefore, that a signed special consent form be procured from the patient before any of the following procedures are carried out.

1. All major or minor surgery which involves an entry into the body, either through an incision or through one of the natural body openings.
2. Any procedure in which anesthesia is used, whether an entry into the body is involved or not.
3. All nonoperative procedures which involve more than a slight risk of harm to the patient, or which involve a change in the patient's bodily structure.
4. All procedures where radium or x-ray is used in treatment.
5. All procedures which involve electroshock therapy.
6. All other procedures determined by the medical staff and the administration to require a special consent.

After discussion, these procedures should be listed to provide guidance to administrative personnel and the medical staff. Any question as to the necessity of obtaining a special consent of the patient should be resolved in favor of procuring the consent.

Use of this form is not required upon admission to the hospital, unless a procedure which would normally call for a special consent form is to be done immediately upon ad-

(*Continued on Page* 170)

Although most hospitals follow some of the four essential elements of sound business organization, the author contends, they seldom use all of them

It's Hospital's Business To Be a Business

Karl S. Klicka, M.D.

WHETHER hospitals are, or should be, regarded as big business and operated on a business-like basis is still a subject of controversy among hospital administrators. Some of them argue that a hospital is not a business and rest their case on the fact that profit is not a hospital's primary motive.

Regardless of the profit motive as a criterion, there are other strong arguments for conducting a hospital on the same principles of efficiency, system, practicality and thoroughness that characterize the successful business.

Four essential elements of a sound business organization are equally important to hospitals. They are:

1. A clearly defined objective.
2. Sound planning, both short-range and long-range.
3. A practical and functional organizational structure.
4. Good management.

No business can succeed without all four of these elements, but, strangely enough, hospitals frequently operate without them. A hospital may follow one or some of these practices, but seldom all four. Trustees and administrators are beginning to feel the lack of these elements and to recognize that the absence of one or more may be the cause of some troubled situations.

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A Clearly Defined Objective

ADMISSIONS: Few hospitals know their objectives well enough to spell them out in writing. They should.

It is common to find statements in the constitution and by-laws of a hospital, stating that, "Its doors will be open to all the sick, rich and poor alike, regardless of race, color and creed." But very few hospitals actually operate on such a broad policy. There are definite limits to the charity the hospital can extend, and there is usually a policy regarding the types of patients admitted. This latter is the unwritten policy and often it is not generally known to all members of the board of directors or the medical staff, let alone the administrator, although he usually is the best informed.

CHARITY: Too few hospitals actually budget the amount of charity they will extend in any one fiscal period.

Charity is usually regarded as one of the costs of operating a hospital and is a responsibility that community hospitals accept in recognition of their nonprofit status. This is commendable but there is really no excuse for leaving this important community service loosely defined. Business firms give large sums of money to charitable enterprises that are in the business of providing necessary community services. Hospitals are one of these. Business firms attempt to measure their contributions to charity, and successful firms limit these amounts to what they can afford. So should hospitals limit their charity to their ability to give away services, and when their charity exceeds their resources, it is only proper, as well as good business, to bring this to the attention of their communities, so that contributions can be solicited to match the charity extended by the hospital.

The charity that hospitals give in the form of service to indigent patients is made possible through gifts made to them by industry and charitable individuals, income from their endowment if they are fortunate enough to have one, and from income which is in excess of their expenses. In business, this last source would be called a profit, but in hospitals it is referred to as the net gain. Some of this net gain, or surplus from operations, should be used to help meet the requirements of indigent patients.

In general, it would appear that when these charitable requirements are heavy they could best be met by soliciting annual contributions from the community specifically for this purpose. The American public traditionally has given freely when the need for the contributions is clearly stated. But in large cities, the chari-

Annual Fund Drives May Give Wrong Impression

HOSPITAL management in many instances is much better than is generally recognized, and often is more businesslike than many businesses. The common misunderstanding that hospitals are poorly managed stems from the unfortunate and persistent habit that many hospitals seemingly cannot break: the traditional habit of conducting an annual drive for contributions to make up the operating deficit.

Where this custom persists, it is usually explained on the basis that this technic is used to keep the image of the nonprofit and charitable hospital before the public.

The public, however, frequently interprets the operating deficit as a reflection of poor management and is likely to express this view with such comments as, "If they ran that place like a business, they wouldn't have a deficit." To this comes the defensive reply: "Oh, but you see, hospitals really aren't businesses. We are a health service and we need your support to survive." John Q. Public shrugs his shoulders, digs into his pocket, gives and mumbles under his breath: "If I operated my business the way they operate theirs, I'd go broke!"

Hospitals would do well to stop annual drives for funds, unless there is a specific need for them to support charitable activities, teaching or research programs.

It is also proper to solicit funds for capital needs, such as the expansion of the hospital or the erection of a new hospital building. Such fund requirements should be stated quite clearly, however, so that the public knows precisely what use will be made of its money. ■

table requirements are so great that contributions from the public can no longer meet the needs and it is necessary that city or county governments reimburse hospitals at their cost for providing care for public assistance patients. Many city and county governments are recognizing that it is good business to support voluntary hospitals in this way, rather than to build their own charity hospitals.

EDUCATION: Although teaching programs are developed for the training of professional personnel in most hospitals, the extent to which a hospital will commit itself on a definite long-range basis in these various programs is seldom defined.

Increasingly, hospitals are facing the question of whether to maintain an intern-resident program, particularly if these hospitals are not affiliated with a medical school or if they are too small to offer a comprehensive training program. The question of whether technicians will be trained in the laboratory, x-ray department, and other ancillary diagnostic service areas must be answered. Will the hospital operate a school of nursing? If it is a large community hospital and maintains a large intern-resident program, should it attempt to develop a medical school affiliation so that it can aid in the teaching of medical students as well?

Teaching is expensive and therefore bears a direct relationship to the general financial policies of the hospital. But the average hospital recognizes that it must conduct teaching programs at some levels merely to meet its own requirements for professional personnel. Also, hospitals must consider their community responsibility, for hospitals have traditionally been expected to teach, as well as to care for the indigent.

Planning

Planning should be approached in its broadest aspects and should, of course, extend beyond the individual hospital. (The phrase, "No man is an island," applies to hospitals as well as to men.) Hospitals, therefore, as they plan for their future should take into consideration the plans of other hospitals in their community. Whereas businesses often do their planning secretly, hospitals should plan on a relatively open basis.

The reason is simply this: When hospitals expand their facilities or erect new buildings, the major portion of the funds necessary for construction comes from community contributions. These funds are by no means unlimited. Contributors give money to hospital projects with the hope that every dollar contributed will be used as wisely and as efficiently as possible in the best interest of the community. To assure this, hospital planning must be community oriented, and each hospital should coordinate its planning with that of other hospitals serving the community.

Something needs to be said about how this planning should be done. Individual businesses plan for themselves. The larger the business, the more likely it is to have a special planning division, but many businesses use professional organizations to assist in their long-range planning. Hospitals should include in their organizational structure a planning committee which can meet most of the planning requirements for the hospital. For special and difficult planning projects hospital consultants can provide needed services.

For over-all community planning, hospitals are finding that they can usefully combine their interests and sponsor an organization which is given the responsibility for objective community planning for the hospitals and for the performance of research in the utilization of hospital services in the community. Such organizations already exist in many cities.

Communities in which there are two or more hospitals should create a central authority in the form of a board of directors that has the re-

Hospitals should try to keep their expansion plans out in open

sponsibility for over-all hospital community planning. The size of the community will determine whether its planning will be conducted by creating its own staff or whether it will solicit the services of one of the metropolitan planning organizations that may make its services available to near-by communities. Professional hospital consulting firms are available for community planning services. Such an organization should be employed on a retainer basis so that a single organization can assume the long-range responsibilities for planning the community hospital system.

Medium-size metropolitan areas that can maintain their own planning organizations might very well limit their staffs to planning and counseling, and leave research to the larger metropolitan organizations with whom they could establish a working relationship. Research is important and must be an ongoing part of the nationwide planning movement, but judgment in each local area will determine to what extent research will be done by the individual planning groups.

Organization

Sound business enterprises follow carefully developed organization charts in their general operation. The principle is a simple one. If everyone knows what is expected of him, and the limits in which he works, the working climate is close to ideal. Successful businesses recognize that it is important for everyone to know who is the top authority, and to whom he is responsible.

The person in authority must respect the delegation of authority that he makes. He should restrict himself to giving orders and instructions only to those employes directly responsible to him. He should follow the chain of command downward, as he expects it to be followed coming up. In essence, this is the army system, but it also works well in business. It should apply to hospitals as well.

In the hospital organization, the area that requires the greatest clarification is at the very top. The complementing responsibilities of the president of the board of trustees and the administrator of the hospital are frequently poorly defined and the distinction between policy responsibility and executive responsibility is not clearly made.

It would help, perhaps, if the person responsible for carrying out the operational and administrative functions of the hospital had a title that described his activities more precisely. At present, the list of titles used is long and bewildering. This person is the chief operating executive and general manager of the hospital, responsible for executing the policies established by the board of trustees, and it is important to show this clearly on the hospital organizational chart. The president of the board of trustees should compare his position to that of chairman of the board of directors in industry and consider his function as one of directing the formation of policy as distinct from implementing it.

The chief operating executive functions best when he sees himself on a line projected toward the important objectives of the hospital, but operating within the confines of the budget and the policies established by the board of trustees. Hospital executives are being trained today to do this. Boards of trustees should enable the executive to utilize his training and experience to the fullest.

It is at the committee level that members of the board of trustees seem to function best. Business today uses the conference technic in much of its decision making, and this practice finds its counterpart in the committee structure of the typical hospital board. The chief operating executive of the hospital should serve ex officio on all these committees with the exception, perhaps, of the finance committee.

Management

Management in its broadest sense is the result of properly mixing all the elements discussed in this article. Given a clearly defined objective, with proper short-range and long-range planning available to guide the organization toward that objective, plus a practical and functional organizational structure with a well trained executive at its head, good management should be expected.

Business has found good communications with its stockholders to be essential. Hospitals are well advised to follow this example. It is a reflection of good management, therefore, for a voluntary hospital to publish an annual audited financial statement, showing the public it serves how it spent the money it took in.

If there is a year-end loss this should be explained. If a hospital makes a profit the report should show this clearly.

The financial statement should be complete enough to reveal the main categories of cost, not on a departmental basis alone, but also on a service basis. Operating expenses pertaining to inpatient and outpatient services reveal one type of service and the portion that charity is responsible for should be clearly shown. Teaching and research expenses should also be presented in understandable form.

Hospitals have for too many years been operated as secret societies. This era has passed and good management will give evidence of an awareness of the new age we live in and operate hospitals accordingly. The more the public knows about hospitals, the more it will understand them. Communicate fully with the public you serve. It will reward you with a new respect. ■

Which Nurses Join Professional Organizations?

This study of the characteristics of the members of professional nursing organizations indicates that these groups may have to develop new appeals if they hope to attract the younger, less highly educated nurses

Rodney F. White and Rose K. Goldsen

MORE nurses, younger nurses, and less highly educated nurses will have to be persuaded of the benefits of membership in the American Nurses Association and the National League for Nursing if these associations hope to play an increasingly important role in determining the direction in which nursing will develop, according to responses to a current study of 1000 registered nurses in New York State.[1] As matters now stand, membership in the professional associations is highest among nurses who are single, more than 35 years old, possessed of a master's degree, and engaged in nursing administration and education.

Of the 1000 surveyed, only 588 replies are used in this analysis since these are the ones who reported that they were employed full time at the time of the study. Both those who were not employed and those who were employed only part time understandably reported fewer professional memberships as shown on the accompanying table 1.

The first interesting observation to emerge from the study is that, even among those nurses working full time, only 42 per cent reported membership in the major national nursing association (the American Nurses Association),[2] and about one-third of them stated that they belong to no professional nursing organization at all.

Although the reasons for this were not investigated directly in the study, remarks obtained from our interviews and questionnaires support the conclusions of earlier research that many nurses are professionally apathetic or are unaware of the benefits to be obtained from membership.[3] Others either are not convinced that they derive any benefits from membership or believe that they are likely to share in any gains that the association is able to obtain whether they are members or not.

Because it is important to the effectiveness of any professional association to persuade a high proportion of eligible persons in the occupation to become members of the association, it is not surprising that the recent revision of the professional nursing code includes a new item which states that "the nurse has responsibility for membership and participation in the nurses professional organization."[4]

Characteristics of Members

Since less than half of the nurses report membership in the A.N.A. and fewer than 15 per cent are members of both the N.L.N. and A.N.A., it is of interest to see whether those who have joined those organizations differ in any important respects from those who have not. Analysis of the data from this study suggests that

Table 1 shows that nurses employed full time are more likely to join professional organizations.

Table 1 — Nursing Association Memberships by Work Status
(Per Cent Reporting Each Type of Membership)

Memberships	Employed Full Time No.	Employed Full Time Per Cent		Employed Part Time No.	Employed Part Time Per Cent		Not Employed No.	Not Employed Per Cent		Total
Both A.N.A. & N.L.N.	79	13%	42	7	4%	23	7	3%	14	93
A.N.A. (but not N.L.N.)	172	29		34	19		26	11		232
Other	127	22		28	16		45	19		200
None	191	32		107	59		145	62		443
No answer	19	3		4	2		9	4		32
Total	588			180			232			1000

[1]This is the same proportion which has been estimated nationally. See American Nurses Association, Facts About Nursing (1960 Ed.).

[2]For example, see Hughes, Hughes and Deutcher: Twenty Thousand Nurses Tell Their Story. Philadelphia: Lippincott, 1958.

[3]See Code for Professional Nurses, Am. J. Nurs., 60:77 (January) 1960.

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[1]This report is drawn from a larger study of the selection or rejection of nursing as a career which is directed by Dr. Robin Williams and Prof. Goldsen of the department of sociology and anthropology at Cornell and is financed by a grant from the U. S. Public Health Service.

NURSES OFTEN VIEW THEIR OCCUPATION LARGELY AS AN INTERLUDE

there are significant differences between the members and nonmembers.

In the first place, there are sizable differences in reported membership between the various fields of nursing. (See Table 2.) On the one hand, close to 90 per cent of those who are currently in schools of nursing report membership in the A.N.A., and nearly three-quarters of them are members of the N.L.N. as well. These figures are not particularly surprising, of course, since the educational institutions in any occupation can be expected to be instruments of professionalization and since the N.L.N. includes educational improvement as one of its major objectives. On the other hand, these membership levels for the field of nursing education are in sharp contrast to most of the other fields and particularly with that of office nursing where 50 per cent report no association memberships and less than 20 per cent are in either the A.N.A. or N.L.N.

Related to this are the differences in membership rates in relation to the positions in which the nurses are currently employed. (See Table 3.) Those in administrative and teaching positions include a much larger proportion who are members of the national associations than do those in lower level positions. There is little difference, however, between the proportion of head nurses who are members and the proportion among general duty or private duty nurses.

Membership also varies considerably in relation to age and marital status of the nurses surveyed. (See Table 4.) Whereas close to 50 per cent of nurses over 35 years of age report membership in the A.N.A., only a third of the nurses under 35 do so, and between 40 and 50 per cent of the latter belong to no professional organizations.

This suggests that many younger nurses do not develop a professional identification with their occupation during the period of their education, but only arrive at the kind of professional commitment which is reflected in joining a professional association after they have spent a considerable time in the field. In addition, the married women among the nurses in this study reported fewer professional memberships than either the single women or those who were widowed or divorced at the time of the survey. Both these findings probably are related to the fact that most women, in contradistinction to men, have only a contingent commitment to their occupation and often see it largely as an interlude prior to marriage and motherhood.

One further characteristic which appears to be strongly related to membership in professional associations is the educational background of the respondent. (See Table 5 on opposite page.)

When the nurses are divided into groups according to the extent of

As this table indicates, there are sizable differences in reported memberships in the A.N.A. and N.L.N. among the various fields of nursing.

Table 2 — Nursing Association Memberships by Field of Nursing[a]

(Per Cent Reporting Each Type of Membership)

	No. Reporting	Nursing Schools	Public Health	Hospital or Other Institution	Private Duty	School Nursing	Industrial Nursing	Office Nurses
Both A.N.A. & N.L.N.	(79)	71% } 87	14% } 36	[%01 } 41	3% } 50	2% } 38	3% } 35	2% } 19
A.N.A. (but not N.L.N)	(172)	16 }	22 }	31 }	47 }	36 }	32 }	17 }
Other	(127)	3	33[b]	15	11	48[c]	32	27
None	(191)	10	30	40	34	14	32	50
No answer	(19)	—	1	4	5	—	1	4
Total		100	100	100	100	100	100	100
Number in each field[d]		58	72	225	58	42	60	57

[a]The total number of respondents represented in this and subsequent tables is 588 — the number in the sample who reported that they were working full time. The numbers in each membership category are shown in parentheses in column 1 of the table.
[b]Seven per cent are members of N.L.N. but not A.N.A.
[c]Nearly half the school nurses report only membership in the state school-nurse-teachers association. Many of them also belong to the state teachers association in addition to (or instead of) their nursing membership(s).
[d]Sixteen respondents checked other fields of nursing or did not answer this question.

their formal education, the higher the level of education of the group, the higher is the proportion reporting membership in the A.N.A. or N.L.N. For example, more than 80 per cent of those possessing master's degrees reported membership in the A.N.A., whereas only a third of those with just a nursing diploma did so. These differences may reflect a number of things, but are probably related, at least in part, to the increased investment in the occupation that a nurse feels after pursuing further education.

Members' Views of Occupation

Since the professional organizations in nursing, like those in other occupations, are in a position to influence the direction in which the field develops, it is interesting to compare the views which members of these organizations have of their occupation with those of nonmembers. Given the differences in both position and characteristics between members and nonmembers reported earlier in this paper, it is not surprising that the ways in which these two groups view nursing differ also.

By and large, the major difference in orientation is that the members of the national nursing organizations take a more professional view of their work, as this is generally defined, than do the nonmembers.

If one examines certain items

(*Continued on Page* 168)

Tables 3, 4 and 5 show type of position, age, marital status, and educational background of members compared to nonmembers of nursing organizations. Table 6 indicates members were more likely to feel a commitment to nursing as their life's work, and Table 7 compares disappointments found in nursing as felt by members and by the nonmembers.

Table 3 — Nursing Association Memberships by Current Position

(Per Cent Reporting Each Type of Membership)

	No. Reporting	Administration or Teaching		Head Nurses		Private Duty		General Duty	
A.N.A. & N.L.N.	(79)	34%	62	37%	35	31%	31	4%	10
A.N.A. (but not N.L.N.)	(172)	28		33		28		26	
Other	(127)	18		21		23		26	
None	(191)	19		38		40		43	
No answer	(19)	1		6		6		1	
Total		100		100		100		100	
Number in each field		197		95		89		175	

Table 4 — Nursing Association Memberships by Age Group and Marital Status

(Per Cent Reporting Each Type of Membership)

	No. Reporting	AGE			MARITAL STATUS				
		35 Years or Under		Over 35 Years		Single		Married		Other	
Both A.N.A. & N.L.N.	(79)	8%	33	16%	48	21%	49	6%	34	15%	50
A.N.A. (but not N.L.N.)	(172)	25		32		28		28		35	
Other	(127)	21		22		19		24		20	
None	(191)	44		26		29		38		29	
No answer	(19)	2		4		3		4		1	
Total		100		100		100		100		100	
Number in each field		211		377		236		251		101	

Table 5 — Nursing Association Memberships by Educational Background

(Per Cent Reporting Each Type of Membership)

	No. Reporting	EDUCATIONAL QUALIFICATIONS							
		Master's Degree		Bachelor's Degree Plus Diploma		Bachelor's Degree		Diploma Plus Some College		Diploma Only	
Both A.N.A. & N.L.N.	(79)	66%	82	35%	70	29%	56	5%	38	4%	33
A.N.A. (but not N.L.N.)	(172)	16		35		27		33		29	
Other	(127)	14		11		14		29		22	
None	(191)	4		19		30		30		41	
No answer	(19)	—		—		—		3		4	
Total		100		100		100		100		100	
Number in each field		44		46		51		166		263	

Table 6 — Professional Attitudes of Nurses by Membership Status

		Member of A.N.A. or N.L.N. (256) Per Cent	Others (332) Per Cent
Consider current work in nursing as . . .	Principal Career or Life Work	51	30
	Other	49	70
Commitment to nursing*	High	59	48
	Low	41	52
Belief in nursing as a distinct discipline*	Strong	35	26
	Other	65	74
Effort to keep up with professional activities	Great Deal	39	15
	Other	61	85
Belief in need to upgrade occupation*	High	70	59
	Low	30	41

*Based on use of a Guttman scale. Details available on request.

Table 7 — Disappointments in Nursing Expressed by Nurses Maintaining Professional Memberships Compared With Nonmembers*

Number Reporting	Members of A.N.A. (281) Per Cent	Others (337) Per Cent
Salaries	47	55
Other nurses	27	27
Routine	23	36
Hours	18	21
Auxiliary personnel	16	21
Amount of patient contact	13	8

*Respondents could check as many items as they wished.

ABOUT PEOPLE

Administrators

A. Chester Conrow has been appointed administrator of St. Barnabas Medical Center, Newark, N.J., succeeding Dr. George C. Schicks, who died recently. Mr. Conrow, associated with St. Barnabas for the last 10 years, formerly was associate director and controller. He is a graduate of Ryder College, and also attended Harvard and Columbia universities.



A. C. Conrow

Newman M. Biller, formerly executive director of Home for Aged and Infirm Hebrews, New York, has been named executive director of the Jewish Chronic Disease Hospital, Brooklyn, N.Y. Previously, Mr. Biller was associated with Montefiore Hospital, Bronx Hospital, and Beth Israel Hospital, all in New York. He served as special assistant to the governor of New York on problems of the aged and is a lecturer in hospital administration at the School of Administrative Medicine, Columbia University.

Charles T. Davis, former administrator of Terry County Hospital, Brownfield, Tex., has been named administrator of Beverly Hills Sanitarium, Dallas.

Albert T. Hume, M.D., is the new manager of Veterans Administration Hospital, Marlin, Tex.

William L. Stone has taken over duties as administrator of Ennis Municipal Hospital, Ennis, Tex. Previously, he was administrator of Chocolate Bayou Hospital, Spring Branch Memorial Hospital, and Lockwood Hospital, all in Houston.

David A. Garrett will succeed **Fred R. Higginbotham** as administrator of Baptist Memorial Hospital, San Antonio, Tex. He has been assistant administrator since 1954. Mr. Garrett is a past president of the San Antonio Hospital Council.

Doris Stephenson, R.N., has been appointed administrator of Shriners Hospital for Crippled Children, Spokane, Wash., succeeding **Emma N. Sargent.**

Thomas Royster Howerton, administrator of Moore Memorial Hospital, Southern Pines, N.C., has been appointed administrator of the proposed Wilson Hospital, Wilson, N.C.

Paul S. Ellison, assistant administrator of Charlotte Memorial Hospital, Charlotte, N.C., has been appointed administrator of Lowrance Hospital Inc., Mooresville, N.C. He succeeds **Charles E. Cauthen Jr.,** who resigned.

Charles G. Skinner, Bureau of Hospital Administration, University of Michigan, Ann Arbor, has been appointed to succeed **Robert G. West** as administrator of Foote Memorial Hospital, Jackson, Mich.

Dr. Harris F. Bunnell has been appointed superintendent of Eastern State Hospital, Medical Lake, Wash. He had been acting superintendent for four months since the resignation of **Dr. G. Lee Sandritter.** Dr. Bunnell had joined the Washington State Department of Institutions in 1958. In another appointment at the hospital, **Laurel V. Nelson** was appointed administrator to plan, organize and direct all hospital services except those directly related to medical services and treatment. Mr. Nelson is a graduate of the hospital administration course at the University of Minnesota and previously was assistant administrator of Bethesda Hospital, St. Paul.

Robert J. Shanko has been appointed evening administrator of Mount Sinai Hospital, Chicago. Mr. Shanko received his master's degree in hospital administration at Washington University, St. Louis.

Warren Stearns has resigned as administrator of Fort Pierce Memorial Hospital, Fort Pierce, Fla.

Stephen K. Wilson, formerly administrative resident, Orange Memorial Hospital, Orlando, Fla., has been appointed administrator of Cape Canaveral Hospital, Cocoa Beach, Fla., which is now under construction.

J. Albert McNab has resigned as administrator of Cloverleaf Hospital, Miami.

Sister Mary Helen has been named to succeed **Sister Scholastica** as administrator of St. Vincent's Hospital, Indianapolis.

Sister Mary Daniel has become administrator of Memorial Hospital, West Point, Neb., succeeding **Sister Benita Marie** who was reassigned to Good Samaritan Hospital, Zanesville, Ohio.

Stacy Johnson has resigned as administrator of Memorial Hospital, Clarksville, Tenn., to accept a position with the U.S. Public Health Service.

Thomas A. Harrington, for the last five years associate director of Pittsfield General Hospital, Pittsfield, Mass., has been appointed administrator of Mary Lane Hospital, Ware, Mass. He succeeds **Perry E. Curtis.** Mr. Harrington received his master's degree in hospital administration from Yale University. **Harold W. Wicks** has become assistant director at Pittsfield General. Mr. Wicks received a master's degree from Yale in public health.

Frank Meisamer has been named administrator of the Tennessee Tuberculosis Hospital, Chattanooga. He received his master's degree in hospital administration from Northwestern University.

Robert L. Denholm, administrator of University of Colorado Medical Center, Denver, since 1957, has accepted the position of chief of administrative services in the Colorado state department of institutions. Mr. Denholm holds a master's degree in hospital administration from Northwestern University.

Edith P. White is now serving as administrator of Worth County Hospital, Sylvester, Ga. She had been head bookkeeper there for 10 years.

Harry E. Davis, formerly an administrative resident at Hillcrest Medical Center, Tulsa, Okla., has been appointed assistant administrator of Flower Hospital, Toledo, Ohio. He succeeds **James J. Boomgard Jr.,** who has been promoted to associate director of Flower Hospital, in charge of the Crestview retirement project.



Harry E. Davis

(*Continued on Page* 210)

Lehn & Fink
PROFESSIONAL DIVISION

staph newsletter

FOURTEENTH OF A SERIES WITH SIGNIFICANT SUGGESTIONS FOR CONTROLLING CROSS INFECTIONS

How "dirty" do you think your money really is? As a result of the curiosity of the Central German Bank about currency as a potential disease spreader, the following headline appeared in the July 25th issue of Medical Tribune, "Germ Count Shows U.S. Dollar Healthiest Money". It seems U.S. currency has fewer germs per bill than any other: U.S., 73; Nationalist China, 230; Spain, 210; Morocco, 163, etc. I wonder what the count is on the much talked about "Hospital Dollar"?

A widely renewed interest in TB seems to be indicated by the stepped up California Public Health program to eradicate TB—as well as by the reported research on vaccines, more effective drugs and ways to improve case-finding. Even with deaths reduced in recent years, tuberculosis is still the No. 15 killer—topping polio, meningitis and influenza combined. But it's the thousands of undetected cases that can create a big problem for your hospital. They may be visitors, patients, or personnel. That's why we are always emphasizing the fact that all Lehn & Fink disinfectants—Amphyl®, Lysol® and O-syl® disinfectants, Tergisyl® detergent-disinfectant and Amphyl® Spray disinfectant-deodorant—are tuberculocidal as a part of their total spectrum microbicidal action. Would you like specific information for disinfection around known TB patients? If so, just let us know.

And now another judgment against the hospital in a staph infection suit! A logger in the Northwest claimed permanent disability from staph infection when hospitalized for a hip injury. Damages claimed were $100,000. Jury awarded patient $67,839. (Hospitals, J.A.H.A., July 16, 1961)

"But our hospital is different" is a comment we frequently hear when discussing infection control with some of our hospital friends. If you have thought or said this, you have some pretty good backing in Dr. Carl W. Walter, Surgeon, Peter Bent Brigham Hospital, Boston, and Associate Clinical Professor of Surgery at Harvard Medical School.

As moderator of a symposium on "The Hazards of Surgical Infection" held in June in New York before a session of the International College of Angiology, Dr. Walter made the point that it is well to remember that "each hospital is epidemiologically unique" so that "there is no uniform answer to this problem" (infection control). The complete report covering the necessity for doing everything possible to achieve and maintain a hygienic atmosphere in every hospital will be published later in the year. In the meantime, why not write us for a copy of the article by Dr. Walter and Dr. Ruth B. Kundsin, "In-Use Testing of Bactericidal Agents in Hospitals", from Applied Microbiology, March 1961. We'll be glad to send it.

If you're still in doubt about the importance of properly disinfected blankets in reducing contamination from airborne organisms, you'll want to read the report on controlled tests made in a 44-bed surgical ward of a large U.S. Naval Hospital over a 12-week period. Cultures from the treated blankets and air samples from the test ward and two control wards show a "marked reduction in organisms" and re-confirm the residual antibacterial properties of orthophenylphenol. (Control of Microorganisms on Blankets, Hospital Management, August, 1961, page 44)

The article we just mentioned outlines a simple, easy-to-follow method of treating blankets routinely with orthophenylphenol (L&F O-syl®). However, we have a convenient 3"x 9" instruction card on Blanket Disinfection which we will be glad to send on request, along with complete data on O-syl's wide microbicidal effects—staphylocidal, pseudomonacidal, fungicidal and tuberculocidal. If you would like multiple copies of the card and brochure for teaching purposes, just ask.

A review of five years of bacteriologic and clinical experience with pseudomonal infection in 1,091 patients at the University of Virginia Hospital reveals that almost one-third occurred in the last year, 1960. Positive cultures were from the following sources: sputum and tracheobronchial material, 471 patients; ear, nose, throat cultures and infections, 261; bacilluria, 152; colonized wounds, 74; established surgical infections, pure culture of pseudomonas, 23; polymicrobial infections, 110. Six of the 23 patients with pure cultures died. Dr. William R. Sandusky reports the details of these fatal postoperative infections in the June, 1961, issue of Annals of Surgery, page 996.

Since Pseudomonas are so widely distributed in nature and can attack the patient through the skin, urinary tract, alimentary canal, upper respiratory passages and external wounds—meticulous aseptic housekeeping techniques are almost a must for their control. *Have you written for our complete kit on controlling spread of infection in every area of the hospital? It's called "Contamination Control That Works...in your hospital". In addition to specific procedures for use of Amphyl®, Lysol® and O-syl® disinfectants, Tergisyl® detergent-disinfectant, and Amphyl® Spray disinfectant-deodorant, the indexed file kit contains reprints of reports on proven successful control programs and teaching materials for your use. Please write for your kit or, if you prefer, ask us to send one for each of the members of your Infection Control Committee or your own department.*

With every effort being made by everyone in the hospital to keep the total bacterial population of the environment at an absolute minimum, it sometimes becomes a difficult job for those responsible for planning and purchasing to anticipate disinfection supplies adequately. Perhaps Lehn & Fink's experience over a long period of years would help you. Our distributors in your area are glad to sit down with the Purchasing Agent and suggest a plan for scheduled futures deliveries tailored to your requirements. This offers you the best opportunity to take advantage of both quantity and volume prices.

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General Sales Manager
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How To Maintain an Infection Control Program

Lessons learned at Temple University Medical Center in starting and continuing an effective anti-infection campaign can be adapted by other institutions

H. Taylor Caswell, M.D.

AFTER five years of experience, the committee on infection at Temple University Medical Center, Philadelphia, is persuaded that the majority of surgical wound infections can be explained, and a significant percentage can be prevented.

The infection control program outlined here has proved practical at Temple and, we believe, can easily be adapted for use in other institutions, although some of our recommendations would not be suitable in all hospitals and, no doubt, some of them will not satisfy all who are interested in hospital-related infections.

Committee on Infection

The membership of this committee should consist of individuals of stature in the hospital community who are interested in the problem of infection and are willing to give of their time to educate hospital personnel properly and maintain a constant, adequate level of surveillance.

The committee must have strong administrative backing and the rules which originate from it should apply to all who work in the institution. The rugged individualist who has been doing things his own way for the last 25 years with "no infections" must be gently but firmly told that his attitude is no longer acceptable. The committee must be accepted by the hospital personnel as acting directly for administration. If this is not done, then a number of directives are issued which no one takes very seriously. The membership of the infection committee will vary from institution to institution. It should consist of members of the surgical staff, including subspecialties, gynecology and obstetrics, pediatrics and internal medicine. In addition, there should be a representative of administration and the housekeeping department. Including the housekeeper as a committee member can do much to implement some of the changes in housekeeping practice which are thought to be desirable. Committee members representing administration and housekeeping are extremely helpful in advising as to the practicability of changes.

We have found that liberal representation of the nursing staff on the committee is extremely helpful.

Generally speaking, nurses are most conscious of the possibilities of infection occurring in hospitalized patients and are more than happy to present or adopt changes in technic which will improve the infection rate within the institution. On our own committee, the director of nurses is a regular and interested member and, in addition, the nurse in charge of the dressing carriages has been of great help.

In our institution, the keystone of the committee on infection is the member representing the department of microbiology.

It is doubtful that any successful anti-infection program can be initiated without a competent, adequately staffed microbiology department with proper physical facilities to carry out its work. In the modern hospital, microbiology can no longer be looked upon as a poor relation of the department of pathology.

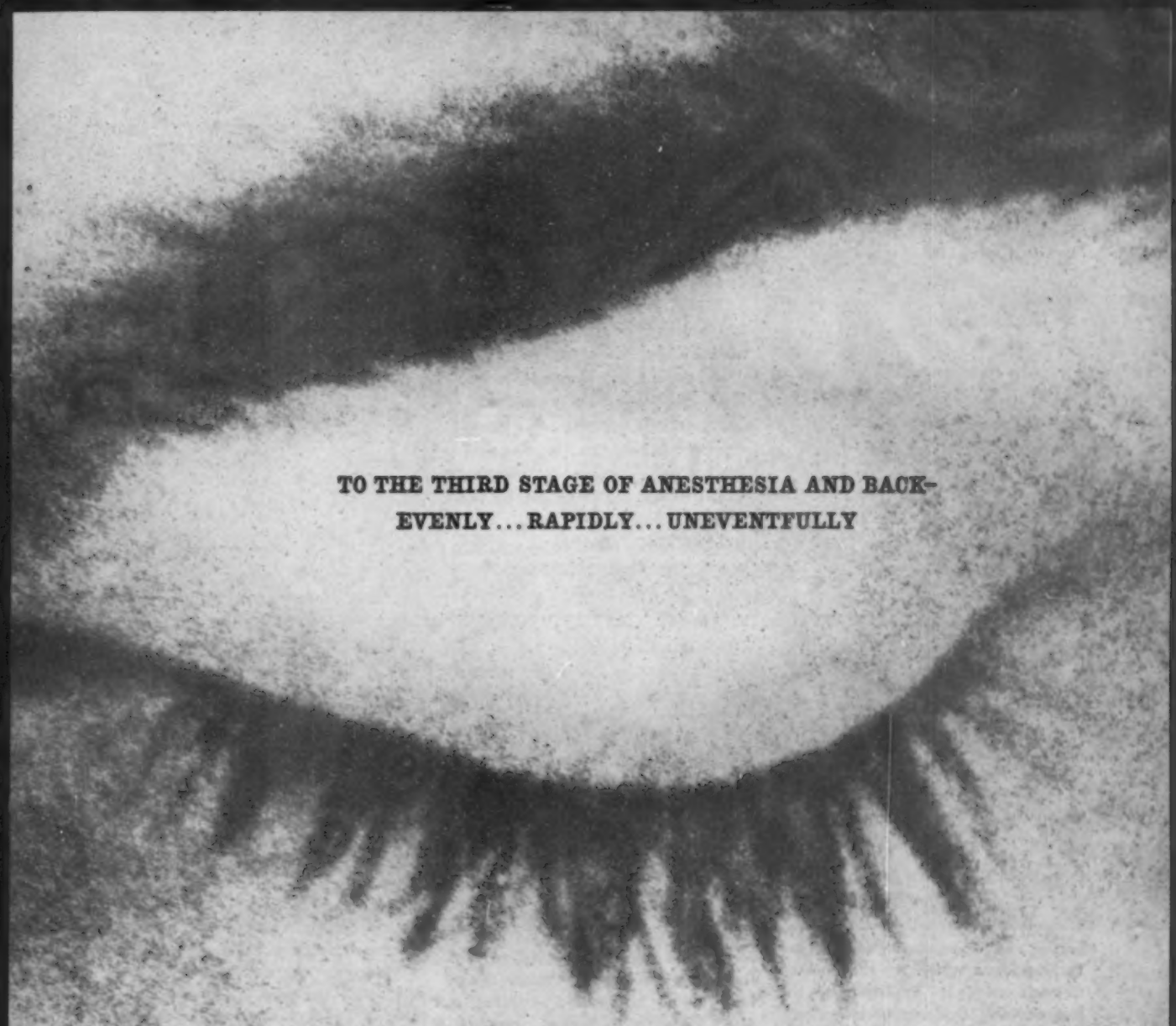
Detecting Surgical Infection

If the definition of infection is complicated, there is less chance of a successful reporting system. It is our feeling that any wound exudate containing pathogenic organisms should be classified as an infection.

We realize that if this criterion is used a small number of wounds in which clinical infections may not be present will be included in the statistics. However, this is far less of an error than not including wounds because they do not satisfy a number of clinical criteria denoting active infection. This is particularly true in patients who have been under antibiotic therapy or cortisone where, frequently, wound infection is far more indolent than is ordinarily the case. Many surgical wounds which are clinically classified as exhibiting serous drainage or liquifying hematoma contain coagulase-positive hemolytic Staphylococcus aureus.

(*Continued on Page* 130)

Dr. Caswell is clinical professor of surgery, Temple University, Philadelphia, and a member of the staff of Temple University Hospital. He is also attending surgeon at Philadelphia General Hospital.



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(*Continued From Page* 128)

On the other hand, we do not recognize redness and swelling alone as evidence of wound infection, for such signs without subsequent drainage almost invariably represent foreign body reaction. Exudate containing pathogenic organisms is the essential for our definition of a wound infection.

The occurrence of infection in any type of surgical wound, whether it be clean or contaminated, must be classified. This is the duty and purpose of the infection committee and, in the classification, it is essential to note the type of surgery in which the infection occurred.

Too often, infections occurring in contaminated wounds are left out of hospital statistics because it is felt that they cannot be considered as originating within the institution. Although this may be perfectly true, it does not mean that, with improvements in surgical technic and wound care, the contaminated wound infection could not have been prevented. The elimination of contaminated wounds in the infection committee's statistics usually leads to the mistaken impression that "nothing can be done about them."

Detection of Infection

It is our strong conviction that the more people who are involved in detecting infection and making out various forms which are then passed through multiple departments, the less effective the detection becomes. Our system has proved to be the best for our institution and we feel it would be efficient in most institutions, provided the staff and administration are willing to accept its requirements. Here is our method:

It is continually impressed upon all departments within the institution that drainage of any character from a surgical wound, no matter how benign it appears to be, must be cultured. Our dressing carriage nurses are insistent that these cultures be taken. On the rare occasion when a physician may decide that it is not necessary, even though the nurse urges him to take a culture, the episode is reported to a member of the infection committee who, in as diplomatic a way as possible, sees to it that it is done. No exceptions are made in either ward or private patients. In institutions where there is some resentment against this technic, the administration should make a firm ruling that it is a hospital requirement. The same attitude is carried into the operating room where cultures are taken in any case in which there is a question of infection during the operation.

The department of microbiology then reports all positive wound cultures at the weekly meeting of the committee on infection. This department makes no effort to investigate the origin of these infections. Each case with a positive culture is assigned to an individual committee member. This committee member sees the patient or his chart and fills out the appropriate infection form. He then presents the case at the next meeting of the committee, at which time it is discussed and classified by the group. It is true that a certain percentage of these cultures proves not to be true infections but we feel that it is far better to include these cases in our survey than to omit them. The occasional case that is not brought to the committee's attention by this system is frequently reported by one of the nurse members.

Constant alertness to surgical and operating room technics which could lead to contamination and possibly infection results in some surprising discoveries. A set of rules hung on the operating room wall means very little. All surgeons should be constantly on guard for errors in operating room technic and there should be no hesitancy in bringing to the attention of other surgeons what are obvious errors. If all who use the operating room adopt the attitude of working together to prevent infection, then any ideas of personal harassment are eliminated.

Specific Control Measures

Operating Room. The permanent operating room staff must consist of competent people in adequate numbers. The operating room is no place to practice penurious economy.

The use of operating room technicians in place of registered nurses can be a dangerous practice in civilian life. The occasional operating room technician who is presented as an example of the desirability of this type of personnel replacing the operating room nurse cannot justify the many who are poorly trained and have mediocre talent. It is incongruous to establish rigid rules of training and accomplishment for the surgeon and then employ a technician with at best two to three months of training on the surgical team.

Bacteriological surveys of the efficiency of autoclaves and air conditioners and of operating room fluids should be carried out at regular intervals. Spot-checks and cultures of surgeons' hands after various periods of operating, and air sampling of the rooms, particularly when the surgeon is talkative, do much to keep the staff alert.

The preoperative scrub for those involved in the surgery should consist of 10 minutes of thorough mechanical cleansing with brush and soap followed by the application of an effective germicidal agent. In our institution, the germicide used is 70 per cent isopropyl alcohol. The inclusion of germicidal agents in the soap used in no way relieves one of the responsibility for adequate mechanical cleansing of the skin. The patient's skin should be clean when he arrives in the operating room and the preoperative prep should consist of mechanical cleansing with soap followed by the application of a tinted germicidal solution.

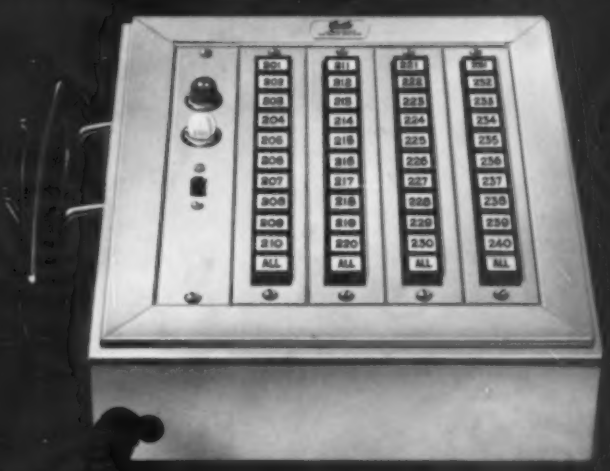
(*Continued on Page* 132)

It Doesn't Take a Czar To Control Antibiotics

It is our opinion that the appointment of a so-called antibiotic "czar" in an institution the size of Temple University Hospital is impractical. Proper antibiotic usage is a matter of education. The members of the committee on infection, representing various departments throughout the institution, can carry out this type of program very effectively on a personal level. Infection rounds on the wards at regular times are an invaluable educational aid in the principles of antibiotic usage for interns, residents and students.

— H.T.C.

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Clean surgeons and dirty patients are an unacceptable incongruity.

Visitors to the operating room suite should be kept at a minimum. Those who do enter must either change their clothes completely and wear conductive boots over street shoes, or the cotton "siren" suit should be available to wear over clothing. The enforcement of such rules in operating rooms where it has been the practice of the staff to drop in to see "if anything is going on" may be the source of some criticism initially. However, within a relatively short time, the necessity for such regulations is usually realized.

Contaminated cases requiring operating room care must be treated intelligently and the room involved should be thoroughly cleansed and all instruments, drapes, operating room clothing, litters treated in the appropriate manner. There should not be a room assigned for so-called contaminated cases alone.

The department of anesthesiology is subject to the same rules of technic as are applied to others in the operating room. Masks and tubing from anesthesia machines are washed with germicidal agents between each case.

Operating room housekeeping and cleansing should be under the direct control of the supervisor in the operating room and every effort should be made to employ the more competent members of the housekeeping staff in this area.

Dressing Carriages. The surgical dressing carriage should be in the care of an experienced graduate nurse who has adequate authority to enforce proper technic in the dressing of surgical wounds, particularly those which are contaminated. The dressing carriage nurse is invaluable in teaching proper wound technic to interns, residents and staff.

Surgical Technic. One cannot make rules concerning this aspect of infection control.

There is no question that the technic used during the surgical procedure plays a major role in determining whether or not infection ultimately develops. Proper surgical technic must be an educational matter. This should include minimal use of catgut, the use of saline lavage of all wounds, and the use of interrupted stainless steel wire for closure of the parietes. Towel technic and local antibiotics in contaminated wounds and emphasis on the fact that a rapid, skillful technic is a requirement of the competent surgeon are all points to be emphasized.

Infection in Personnel. It is an absolute rule at Temple that any member of the operating room team is relieved of duty in the event of a cutaneous infection.

This is done without loss of pay to the individual, who is treated in a central clinic by a competent member of the graduate surgical staff and not returned to duty until all evidence of infection has cleared. The time lost from work and recurrence rate can be greatly reduced by proper management of these individuals. These same rules apply to the surgeon with infection. A surgeon with infection who operates places himself in a dangerous and indefensible position.

The management of nasal carriers of hemolytic Staphylococcus aureus among hospital personnel at Temple is, briefly, as follows:

Nasal Carriers With Active Associated Infection. The nasal carrier with associated cutaneous infection unquestionably should be relieved of all hospital duty and furloughed until the cutaneous infection is completely cleared. In many, the nasal carrier state is on a basis of contact contamination from the cutaneous lesion and clears when control of the infection is established.

Asymptomatic Carriers. In an epidemic situation, the asymptomatic carrier of the dominant bacteriophage strain should be excluded from operating rooms, nurseries and delivery rooms. We feel that they can be allowed to work in other areas and that they should be treated locally in the area of the nasal vestibule with neomycin ointment. They are allowed to return to duty in the so-called critical areas when nasal cultures confirm absence of the carrier state. More than one culture should be taken before an individual is labeled a chronic carrier.

In a nonepidemic situation there is no sound indication for barring asymptomatic nasal carriers from the operating rooms. Frequently, the carrier state is not constant and this can be determined by repetition of the nasal culture. In a nonepidemic situation, routine culturing of operating room personnel is, in our opinion, not necessary.

Tracing Wound Infection Origin

The success of this aspect of infection control depends upon an aggressive detection program. With this type of program, it is promptly realized by the infection committee that there is an increase in surgical wound infections on a specific hospital service.

Usually, the committee member who represents this service contacts the surgical team involved and initiates a survey. It has been our experience that the initial investigation should be directed toward eliminating the presence of cutaneous infection of any type among members of the operating room team involved. At the same time, the operating room supervisor is notified of the increase of infection on the specific service and checks out the efficacy of the autoclaving equipment and other sterilizing procedures used on the affected cases. She also investigates the possibility of innovations in the original technic which may have been adopted without her knowledge by the involved group. The details of surgical technic used in the infected cases are gone over carefully and the preoperative preparation of the patient, including antibiotic therapy, is surveyed. Scrubbing technic is also investigated.

These measures are frequently adequate to solve the problem. If not, then subsequent steps should consist of nasal cultures of all personnel involved in the surgery of the infected cases and the preparation of a table listing personnel present at operation against infected patients. The asymptomatic carrier of the bacteriophage strain responsible for the infection, who proves to have been present at all the operations in which infection subsequently developed, is highly suspect. Finally, the ward or room enviroment of the patients who develop infection is investigated for hygienic defects which can play a part in causing surgical wound infection.

It has been our experience that, although frequently no obvious cause may be found for a "localized" epidemic of wound infections, the investigation itself seems sufficient to end it. This could be due to the fact that there is a general tightening up of technic by the service involved. ■



The Memorial Hospital in Wilmington, Delaware, with a 354-bed capacity treats over 31,000 patients yearly. Equipped with such facilities as the constant x-ray operating room pictured here, ultrasonic cleaning apparatus and one of the few radioisotope centers in the Middle Atlantic States, Memorial Hospital stands ready to serve every need in the heart of the great urban and industrial complex of the Delaware Valley.



Mr. Robert Simons, Director of Pharmacy Service, Memorial Hospital, shown dispensing a prefilled TUBEX Sterile Cartridge-Needle Unit. In addition to his role as Director of Pharmacy Service, Mr. Simons—as one of the founders of the Poison Information Centers—is also kept busy promoting this work not only in Wilmington but across the nation.

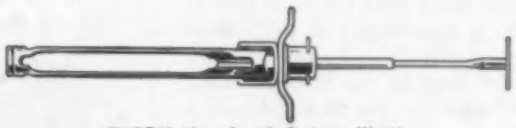
A Contribution to Modern Hospital Management

Mr. Simons comments: "The TUBEX Closed Injection System has been introduced into and is now being used in every department of our hospital. Of the 169,000 injections given annually here at Memorial Hospital approximately 50% are in TUBEX using either the prefilled cartridges or the empty graduated TUBEX Sterile Cartridge-Needle Units.

"This move to TUBEX was made only after a nurses' committee, acting upon the suggestion of our pharmacy committee, had carefully studied and recommended its adoption. We feel that the TUBEX system is the injection program most in keeping with the rigid quality and sterility requirements of good hospital management which we must maintain."



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Hospitals Should Reexamine Use of Sample Drugs

Grover Bowles Jr.

FOR many years hospitals have received generous supplies of professional samples of prescription legend drugs. Some samples are received by direct mail; others are left with the hospital pharmacist by the pharmaceutical representatives, but the greatest source of sample medication probably comes from the physicians on the hospital staff. It is common practice in most hospitals for staff members to send their excess samples to the pharmacy rather than discard or otherwise dispose of them.



Grover Bowles Jr.

Usually hospitals have put sample medication to good use. Some, in an effort to control costs, have used sample medications to fill prescriptions for indigent clinic patients. Other hospitals have served as collection centers for church groups interested in sending drug samples to missions.

So far as is known, hospitals have not sold drug samples nor have they bought drugs from the firms specializing in repackaging of professional drug samples. Recent seizures of mislabeled drugs by the Food and Drug Administration has brought on a tightening of regulations dealing with the dispensing of professional samples of legend drugs.

The F.D.A. manual for pharmacists, *The Rx Legend*, which was distributed to more than a hundred thousand pharmacists in recent months, had this to say about the use of drug samples.

Question: "What should a pharmacist do with sample packages that may come into his possession?"

Answer: "He can, of course, give them to physicians; or he can keep them in the original manufacturer's package and use them in filling prescriptions.

"Repackaging should not be undertaken without checking the legal requirements for repackaging the particular drug involved. For example, certifiable antibiotics cannot legally be repackaged without obtaining F.D.A. certification on the repackaged article. Similarly, 'new drugs' should not be repackaged without obtaining a supplementary new drug application. It has been found, too, that in repackaging samples, different codes of the same material may be mixed, or code numbers or expiration dates may be lost or inaccurately transposed to new labels. Too often the label used on the repackaged material is incomplete, making the repackaged material illegal and subject to seizure and condemnation proceedings."

More recently the F.D.A. has recommended that professional samples of prescription legend drugs not be used for filling prescriptions and that samples coming into the possession of the pharmacist be destroyed. While it appears the drastic reduction in the distribution of professional samples from pharmaceutical manufacturers may eliminate many of the problems surrounding their use, hospitals will want to take a close look at how professional samples of prescription legend drugs are being used. ■

What Can Pharmacist Do With Unused Prescriptions?

"It is a very dangerous practice to accept and return to stock unused portions of prescriptions (or for that matter unused portions of over-the-counter drugs) that have been returned. . . . Many state boards of pharmacy have issued regulations specifically forbidding this practice, and we heartily endorse the actions of these boards as being in the interest of the public health.

"There is no doubt that the pharmacist is legally responsible for any hazards of contamination or adulteration that arise by reason of having mixed returned portions of drugs with shelf stock. Investigations of drug injuries have turned up cases where drugs returned by patrons and subsequently resold by the pharmacist were responsible for the injuries." — *The Rx Legend, an F.D.A. Manual for Pharmacists, Department of Health, Education and Welfare.*

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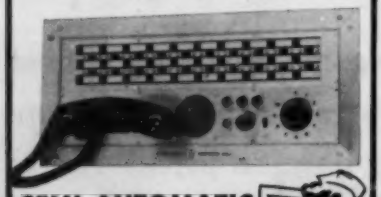
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Why Teach Record Librarians That Physician's Index Is Confidential?

Robert S. Myers, M.D.

ONE bit of utter nonsense still being taught to the students in the medical records librarian schools is the ancient and fallacious doctrine that the physician's index is a confidential record which must be guarded from unauthorized inspection. Nothing could be further from the truth; and nothing is more at variance with actual record room practices.

Evidently the trouble started years ago when some recognized authority in the field of medical records stretched the definition of the word "index," as it related to physicians, to convey a meaning that was not logical or consistent with its general use by hospitals; and this mistake has been copied and repeated in textbooks published subsequently. As a result, the word "index" as it applies to physicians has meant one thing, and as applied to patients, diseases and operations it has meant another.

The correct use of "index" is that defined as "a list describing the items of a collection and where they may be found." This definition is followed almost universally by hospitals.

For instance, the patient's index lists the patients alphabetically with their necessary identification data; the disease index lists the patients with similar diseases, and the operation index, the patients having the same operation.

On the other hand, the corrupted definition of the word "index," in regard to physicians, not only includes the list of patients treated by each physician, which is correct, but also attempts wrongly to record the assessment of the end results of treatment.

If done adequately, such an assessment is a medical audit and has no place in an index of the physician's patients. If done poorly, so as to include only the fact that the patients lived or died, the physician's index is as confidential as the Chicago telephone directory and should be made available to the entire staff.

Actually, the hand-posting methods by which indexes are usually kept are so antiquated, so time consuming, and so burdensome that most hospitals are fortunate to be able to maintain the most rudimentary forms of indexes without the addition of information about the results of treatment. But it is a shame to teach the students that a physician's index is confidential and, as such, may be inspected only by the physician whose work is listed, or by a staff committee responsible for promotions in privileges or rank.

The students remember this nonsense and regard it as gospel when they assume their duties as full-fledged librarians. Then they are jolted by one of several discoveries: There is no physician's index and little hope of maintaining one; the physician's index is a mere listing of patients treated by the physicians; it lists the patients and the fact that they lived or died. But more than this, they discover that it is the established practice in the hospital that the physician's index, if maintained, is available generally for the information of the entire medical staff. This is as it should be.

The physician's index is not a confidential record. Medical records librarian students should not be taught such erroneous theory. They have too much factual information to remember as it is. ■



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How To Select Candidates for the Surgical Technical Aide Program

By Frances Ginsberg, R.N.

IN AN earlier column on the surgical technical aide* program we noted that every hospital has a number of aides, maids, orderlies and practical nurses who might well become excellent surgical technical aides. How can they be sorted out from among all those now working in these positions? It is not easy, but it can be done.



Frances Ginsberg

Perhaps the best way is to talk with their supervisors, who are in the best position to select those who are the brightest and the most willing. They will also be able to point out those who not only learn quickly but also, most important, want to learn. Those they name form the nucleus of the group from whom the selection can be made.

Each member of this group should then be screened according to certain criteria which experience has proved valuable in averting attrition during the course.

The candidates should be no younger than 18 or older than 45 years of age. They should be high school graduates or the equivalent. This should not be an iron-clad rule since inherent intelligence has often proved to be one of the best qualifications when combined with a high motivation. They should be in good physical and emotional health. They should have demonstrated an interest in caring for the sick by a minimum of three months of service in their particular hospital job. They should not, however, be candidates for professional nursing at the time of selection.

Although the evaluation offered by the supervisory personnel, coupled with the screening criteria, is usually valid, judgments can often be colored by other factors.

Therefore, a next step is not only advisable but also necessary. This is a personal interview by the individual who will be responsible for the program. If the interview is properly handled, she can establish to her own satisfaction whether the candidate is interested and willing to learn, industrious and conscientious, mature in his judgments, adaptable, cooperative and courteous, neat, willing to accept constructive criticism, and possessed of mental stability and a sense of humor.

If during the interview it is apparent that the candidate has all of the desired qualifications, in addition to an interest in advance-

*"A surgical technical aide is a selected lay person who, through a well planned and well organized course of instruction, is prepared to function intelligently under the direct and continuous supervision of qualified professional nurses within hospital areas intimately concerned with the principles and practices of surgical asepsis, *i.e.* operating room, delivery room, emergency room, and central service department. . . ." "Surgical Technical Aide Instructor's Manual," published by the American Hospital Association.

Miss Ginsberg is a consultant on operating room nursing and hospital aseptic technics and a member of the Bingham Associates Program at Boston's New England Center Hospital.

This concludes a series of articles on surgical technical aids. The first article appeared in the June issue.



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ment, and the interviewer believes he would be a good candidate, there are two more steps that should be followed.

First, the prospective student should be told as much as possible about the duties and responsibilities of a surgical technical aide. These functions will differ from one hospital to another; therefore, it is important that this explanation only encompass those duties and responsibilities listed under the particular hospital's job description.

Second, since the glamour of this new position can sometimes result in the candidate's overenthusiasm, the interviewer should put off accepting the student at the time of the first interview. He should be asked "to think it over" for a few days and then at a subsequent interview make the decision.

Because such a program involves not only an investment of time and money, but also good patient care, this selection process should be carefully worked out. In addition, every other aspect of the program as described in this series should be planned and carried out just as carefully. ■

O.R. Forum Questions and Answers

Wash Gloves With Detergent

We wash rubber gloves carefully in green soap and rinse them thoroughly. However, we continually face the problem of "sticky" gloves. How can this be avoided?

Hospitals with more than 50 beds should provide an automatic home or commercial type of washing machine for processing rubber gloves, rather than require nurses to hand-wash such gloves. This gives central service responsibility for washing all rubber gloves, and thus enables it to control not only the manner in which gloves are washed, but also ensures their readiness for use. Green soap should not be used in these machines nor, as a matter of fact, in hand washing where no machine is provided. It leaves a film on the gloves. A nonionic commercial detergent should be used and will ensure clean gloves that will not stick.

Don't Boil Rectal Tubes

Should rectal tubes be boiled after use?

No. The ineffective, archaic system of boiling equipment in "fishkettles" or basins should have been discontinued with the advent of the autoclave. Rectal tubes should be thoroughly cleaned in detergent solution, rinsed in tap water, wrapped in paper or muslin, and autoclaved in central service.

Damp-Mop O.R. Floors Between Cases

Should operating room floors be scrubbed between routine cases?

From a practical and aseptic point of view, the floors should be damp-mopped with detergent germicide following each case and effectively terminally scrubbed at the end of each operating day.

Questions regarding operating room practice will be welcome and will be forwarded to Miss Ginsberg for reply in this column.







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Conducted by Jane Hartman

This Study Uncorked Cafeteria Bottlenecks

This work simplification project by the dietary department of Massachusetts General Hospital helped unsnarl traffic lines and speed up service. More important, it resulted in the complete redesigning of the cafeterias for greater efficiency

Maxine Gilson

A WAY to serve increasing numbers of customers, with different needs, in a relatively short time was found by employing work simplification methods in the cafeterias at Massachusetts General Hospital, Boston.

At the time the dietary work simplification committee (see accompanying box) undertook study of this problem, the general cafeteria for staff, students and visitors was serving 1200 meals daily. At the same time, a smaller cafeteria for employes operated, except for a short peak period, at one-third of its capacity.

A subcommittee appointed for this purpose focused first on possible bottlenecks in the existing cafeteria lines and studied the advantages self-service might offer.

Studies by cafeteria personnel indicated that some of the difficulties were: visitors who were unfamiliar with the cafeteria slowed the lines; the student nurses' lunch schedule was such that classes of 150 would arrive at one time; cross-traffic and long cashier lines created confusion; and the customer had to make several stops between the beginning of the line and the dining room table.

The committee recommended the following changes, which were made (see Fig. 2 on Page 144):

1. A sign was posted at the cafeteria entrance to route visitors.
2. A menu board was placed outside the entrance to give customers an opportunity to consider their selections before entering the line.
3. Lunch schedules for student nurses were staggered whenever possible.
4. Both cashiers were placed in the dining room area. Silverware, napkins and condiments were moved from the dining room to an area in front of the cashiers, decreasing the number of stops from three to one.

Figure 1 shows the original cafeteria and equipment. The self-service innovations and new equipment recommended by the committee are shown in Figure 2.

These self-service features proved effective in reducing the work load both before and during the serving period. The regular customers and visitors moved through the lines quickly and easily. But, the speedup did not solve the entire problem.

The work simplification subcommittee then analyzed the utilization

(*Text Continued on Page* 146)

Miss Gilson is assistant director of the dietary department and school of dietetics, Massachusetts General Hospital, Boston.

How Work Simplification Committee Grew

REDESIGNING the cafeterias, as described in the accompanying article, was only one of the projects resulting from the introduction of work simplification principles to the dietary department at Massachusetts General Hospital.

From the beginning, response to the program was enthusiastic. As the first principles were taught in an inservice class, they were almost immediately applied to the work situation.

In fact, the projects became so numerous that communication and coordination became a problem.

The need for many individual conferences during the day resulted in monthly evening meetings to study interdepartment and intradepartment problems.

Participating members of the group are: an assistant director of the hospital, graduate dietitians, dietetic interns, and supervisory personnel.



Kitchen PROVED

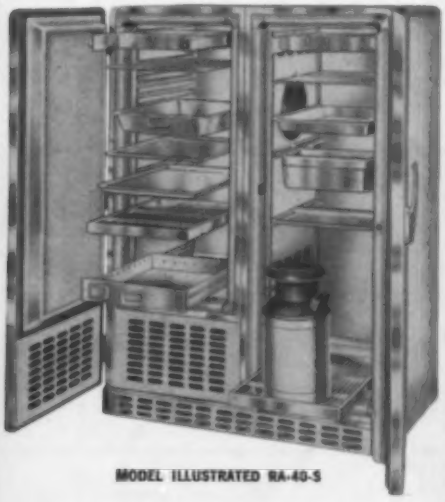
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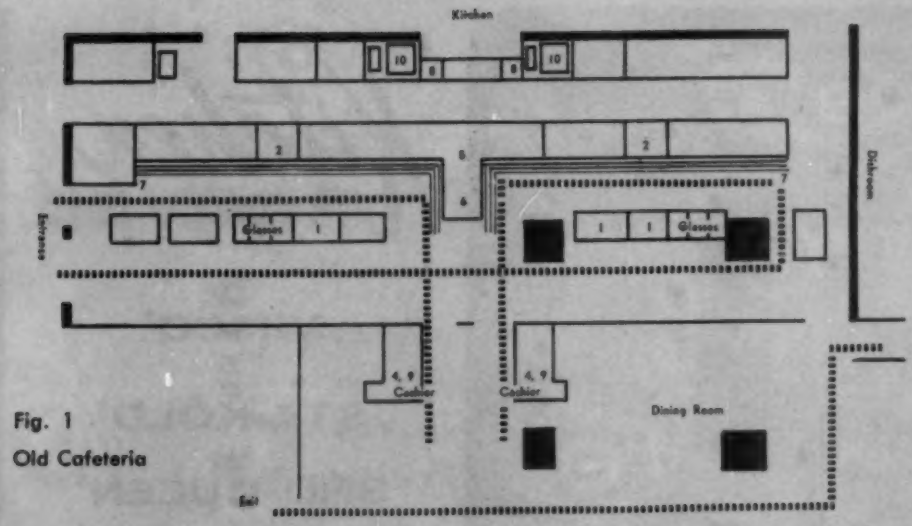


Fig. 1

Old Cafeteria

OLD AND NEW PLANS OF GENERAL CAFETERIA AND DINING ROOM SHOW

FIG. 1—BEFORE

1. Milk, 8 oz. bottles in ice pans
2. Fruit juice, poured, 4 oz. glasses
3. Sugar on condiment table
4. Mustard and ketchup in open bowls on condiment table
5. Jelly in soufflé cups on salad counter
6. Fresh fruit in individual dishes on dessert counter
7. Dry cereal in individual packages, available for breakfast period only, set up in individual bowls on counter
8. Stainless metal ice chests behind counter
9. Cream on condiment table, three small dispensers
10. Coffee in urns

FIG. 2—AFTER

1. Milk dispensers
2. Fruit juice jet spray dispensers
3. Sugar shakers on each dining room table
4. Individual packages of mustard and ketchup on silverware counter
5. Individual packages of jelly on silverware counter
6. Fruit in large bowls on counter
7. Cereal rack attached to front counter, available at all meals
8. Ice makers, built-in
9. Two large cream dispensers, one on each silverware counter
10. Coffee in vacuum makers

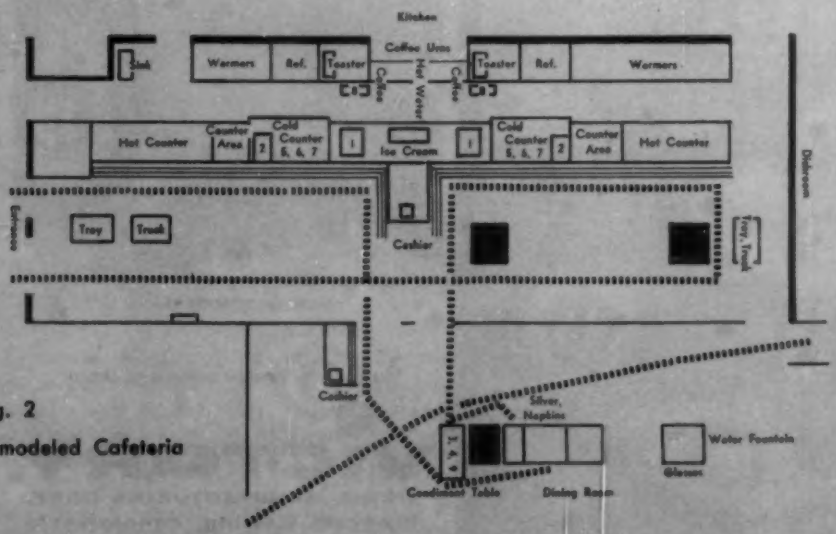


Fig. 2

Remodeled Cafeteria

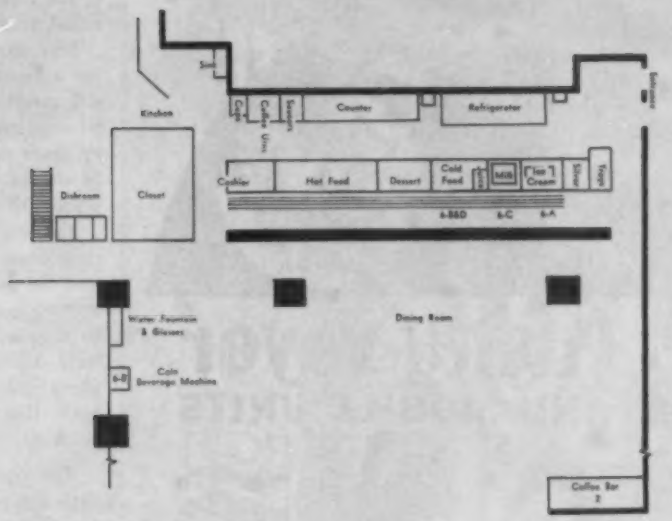


Fig. 3
Old Dining Room

WHAT MINOR CHANGES IN ARRANGEMENT AND NEW EQUIPMENT CAN DO

FIG. 3—BEFORE

1. Partition between counter area and dining room
2. Coffee bar, obsolete area
3. Tables and chairs, wooden, 30 years old
4. Flooring, cement
5. Walls
6. Self-service units
   a. Ice cream, scooped by counter personnel
   b. Carbonated beverages on counter opened and ice supplied at counter; also coin operated machine
   c. Milk in paper cartons on ice
   d. Fruit on counter in individual dishes
   e. Hot beverage counter area
   f. Coffee urn

FIG. 4—AFTER

1. Partition removed
2. Coffee bar removed
3. Tables, refinished with walnut stain; chairs, new aluminum, seat covers in tangerine and turquoise
4. Vinyl plastic tile
5. Walls repainted
6. Self-service units
   a. Ice cream chest, bricks
   b. Carbonated beverages, free play machine
   c. Milk dispensers
   d. Fruit in bowls on small table
   e. Hot beverages, self-service except for hot tea
   f. Coffee in drip percolator

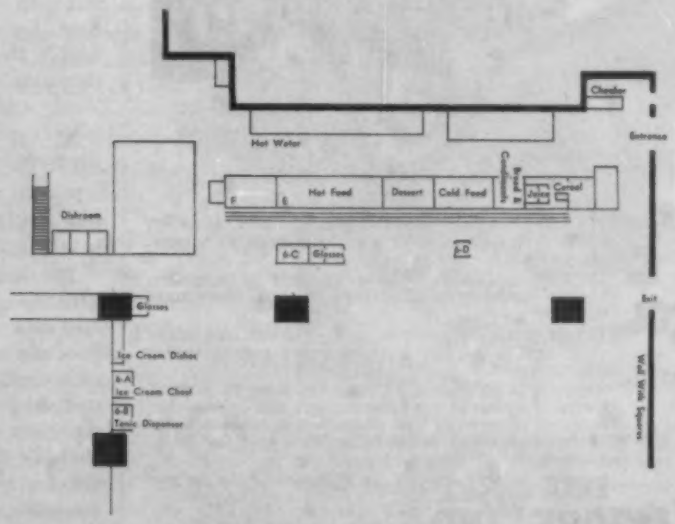
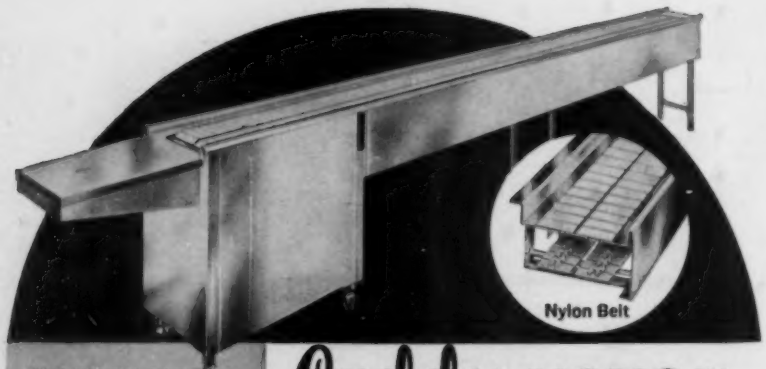


Fig. 4
Remodeled Dining Room



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TEL KEE

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(*Text Continued From Page* 142)

of the cafeterias and conducted a detailed study of lunch patterns.

The committee found that, except for a short peak period, the personnel cafeteria operated at a third of its capacity. This cafeteria also had to open earlier to serve the dietary personnel who would be working during the rest of the noon period.

Further study showed that the student nurses, because of their number and the fact that they were all credit customers, would be an ideal group to shift away from the general cafeteria. The seating capacity of the employe cafeteria (150) also correlated with the lunch scheduling of the students.

The committee therefore proposed that the personnel cafeteria be used for the student nurses at noon and the service for personnel be absorbed by the general cafeteria.

This encouraged the subcommittee to begin plans for a completely self-service cafeteria. One of the members built a scale model of the counter area and dining room, which provided an excellent way to move counters, refrigerators, tables and chairs, and even walls to find the best arrangement. Members of the committee also visited other food service installations to see new self-service equipment in operation.

The student council of the school of nursing worked with the committee on the plans for the remodeling and redecorating and naming the new student cafeteria.

At this stage the hospital architect and maintenance department heads met with the committee to determine costs. Once the estimate was established, the plans were given final clearance by the administration. Work and equipment orders were quickly placed and the work was completed on schedule.

Figure 3 shows this cafeteria before remodeling and Figure 4 shows how it has been changed.

The student nurses are pleased to have their own dining room, the general cafeteria customers find waiting lines are shorter, personnel now feel quite at home in the general cafeteria, the administration thinks that the saving of 80 man-hours a week well justifies the expense of the project, and the work simplification subcommittee is happy to see its project result in improved service. ■

Courtesy National Shrimp Breaders Association



CLAM SAUCE FOR SHRIMP
(Yield: 1½ quarts)

Ingredient	Amount
10½ oz. cans minced clams	6
Garlic cloves, minced	4
Olive oil	½ cup
Salt	1½ tsp.
Pepper	¼ tsp.
Parsley, chopped	½ cup

Drain clams, reserving 2 cups clam liquid. Saute clams and garlic in oil for 5 minutes. Stir in 2 cups clam liquid, salt and pepper. Cover and simmer for 10 minutes. Add parsley.

This Is No Year To Skimp on Shrimp

DIETITIANS now have an opportunity to serve shrimp at a savings.

High inventories at the start of the shrimp season suggest that prices for this "luxury" shellfish will be extra low this year. In addition, U.S. Department of Agriculture reports show that shrimp production is already 8 per cent ahead of last year.

All this boils down to good news for dietitians who need to find popular fish dishes — and for patients who find shrimp in its many forms a welcome change from standard hospital fare.

Fresh, frozen, canned and breaded shrimp are all on the list of plentifuls mentioned by the U.S.D.A. Breaded shrimp is probably the most popular of these, with 69 million pounds being consumed in the U.S. last year, according to the Bureau of Commercial Fisheries.

One way to add a different fish flavor to breaded shrimp is illustrated with clam sauce. Also shown is a simple shrimp sandwich. Four boiled shrimp are placed on each bun. The rolls are then dipped lightly in milk and then in dry bread crumbs. They are placed on greased baking sheets and baked at 400 F. for about 20 minutes

Courtesy Shrimp Association of the Americas



Top: Shrimp with clam sauce provides an unusual combination of flavors that should prove equally adaptable for patient menus and for the personnel cafeteria. Shrimp-in-a-bun, lower picture, is a satisfying hot sandwich with luncheon appeal.

or until brown. One or two shrimp placed on top make this sandwich even more attractive. An easy sauce for this, and other shrimp dishes, can be made by blending together equal parts of mayonnaise and ketchup.

With shrimp so plentiful this year, dietitians will also have an excellent opportunity to experiment with its uses as an appetizer, in salads, and as a garnish, as well as in a variety of main dishes.

For example, a shrimp-avocado aspic offers an unusual combination of appetite stimulating flavors. For this, arrange a row of cooked and cleaned medium-sized shrimp in a thin layer of lemon flavored gelatin in the bottom of a greased mold. Fill the rest of the mold with chilled, slightly thickened gelatin containing more shrimp, diced avocado, and finely chopped celery.

A shrimp and pea casserole is another main dish combination that is unusually satisfying. For this, alternate layers of soft bread crumbs, cooked and cleaned shrimp, and medium cream sauce made with green peas. Sprinkle generously with buttered bread crumbs and bake in a moderate oven until the top is brown and bubbly.

No matter how she chooses to serve it, however, this year the dietitian should have no excuse to skimp on the shrimp. ■



FOOD FOR THOUGHT

Manufacturers Offer Some Spicy Reading on Foods

With the trend toward more gourmet style hospital meals, dietitians are having to concern themselves increasingly with seasonings, flavorings, dressings and garnishes — as well as proteins and calories.

Two new booklets published by manufacturers' associations should be especially helpful. One is a guide to the use of spices, and the other a "how to" handbook on salad dressings.

When To Spice What

"A Guide to Spices" presents a detailed description of available spice products, including their uses and the forms in which they can be purchased.

There is also an unusual chart suggesting combination of spices and spiced sauces for use with a wide variety of dishes.

Other useful information includes tips on how to select spices, how much to use, when to add them in cooking, and a table of equivalent amounts.

This booklet was prepared by the National Restaurant Association in cooperation with the American Spice Trade Association.

How To Dress a Salad

So dietitians will have no excuse for serving the same type of salad dressing day after day, the manufacturers' association has prepared a handy guide to what dressings to serve with various kinds of salads.

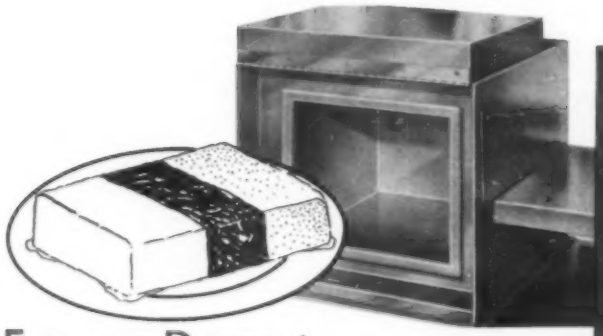
Fourteen different dressings are included on this chart, which also gives directions for using them as sauces and seasonings.

This "How To Handbook," available from the Mayonnaise and Salad Dressing Manufacturers' Association, also provides helpful information on how to purchase, store, handle and serve the various products. ■

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COLD



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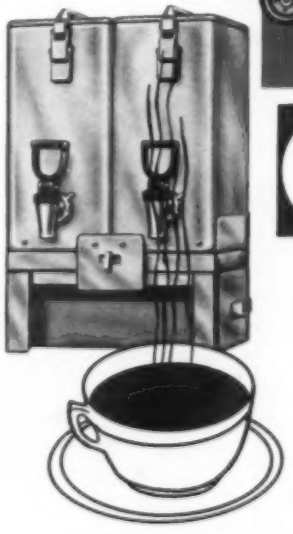


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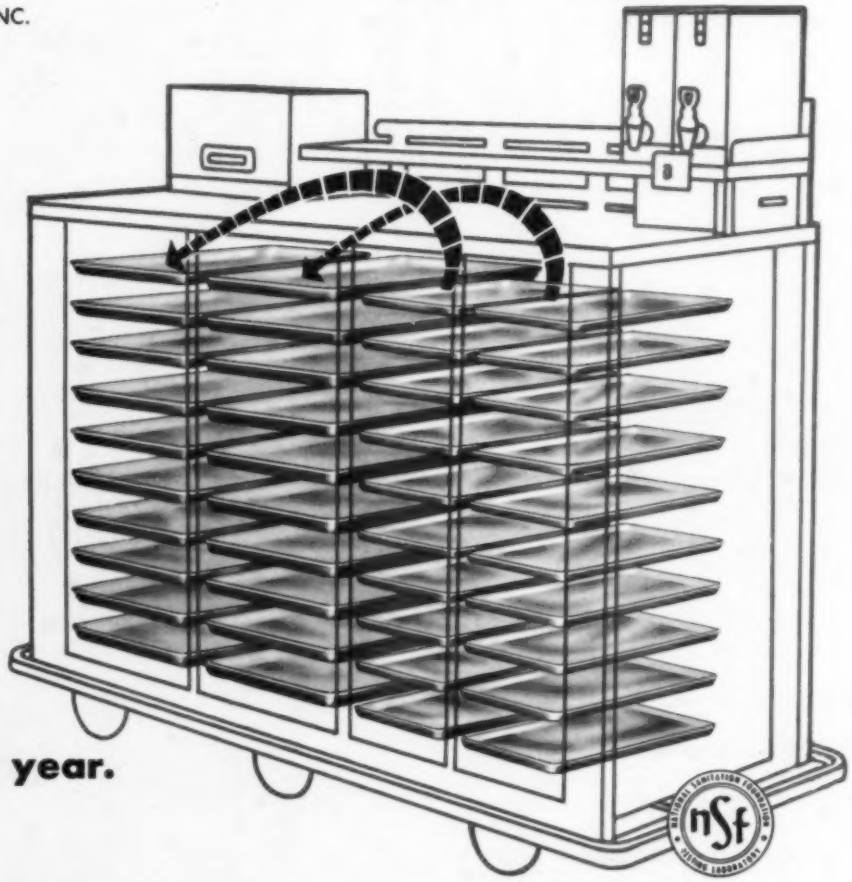
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Meals-on-Wheels open areas make cleaning and proper sanitation easier and quicker. It isn't necessary to remove component parts, brackets, tray guide sections to clean.

Absolute Control by Dietitian

Complete patient tray is delivered to patient exactly as it was made up and checked by supervisor in the kitchen. The new ELECTRA II with side by side oven tray arrangement makes serving on patient floor so easy. If desired, complete serving functions can be performed by nursing staff.

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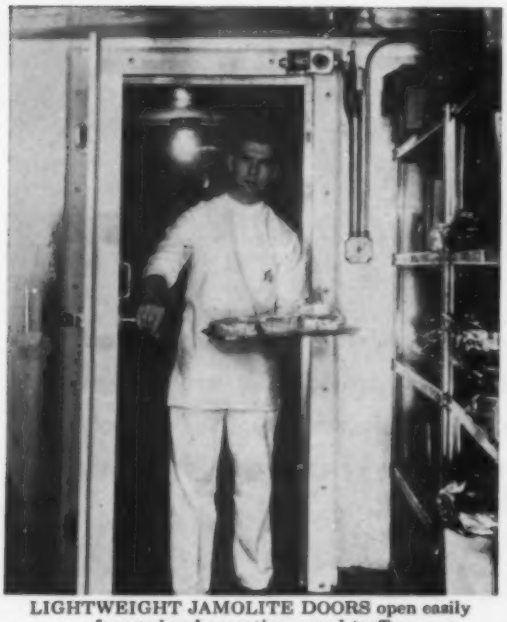
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New Kitchen Equipment Saves Time and Space

Manufacturers — who have been listening to the people who use their products — are designing new kitchen equipment that really does the job — and some that will even do two different jobs

Jane Hartman

IN RECENT years dietitians and food managers have emphasized their food service equipment needs to the manufacturers. These consumers have plied the producers with the question, "Why can't we get the equipment we need?"



Jane Hartman

The exhibition at a recent national food show indicated that purveyors are making a sincere effort to produce versatile, economical, labor saving equipment.

For example, the manufacturer of a power mixing machine demonstrated a power dicer attachment.

Assuring uniform dicing at high speed, this device dices onions, celery, apples, eggs, cucumbers, cheese and many other foods. The attachment boasts several sizes of grids and readily adapts for ½, ⅜ or ¼ inch dicing or slicing. The dicer, which takes just seconds to install, cuts French fries quickly.

Hospitals suffering from limited space in the dishwashing area will be particularly interested in the circular dishwashing machine.

While this type of equipment is not a newcomer, one machine now combines food waste disposer, recirculating water scrapper, power wash, and final fresh water rinse, and requires as little as 12 feet by 6 feet of space. This machine has multipurpose racks that accommodate all types of service as well as trays.

A cold water glasswasher is available, bearing the approval of Underwriters Laboratories, Inc., and the National Sanitation Foundation.

This machine employs cold water, iodophor detergent-sanitizer, and contra-rotating brush action. It takes four seconds to wash a glass so that an average of 450 glasses per hour can be properly washed and sanitized. Recognizing that wiping recontaminates clean glasses, the manufacturer incorporated a wetting agent in the detergent-sanitizer which drains water off the surface of the glass.

One manufacturer, a pioneer in multipurpose equipment, exclusively exhibited a cooker-mixer.

This steam-jacketed stainless metal tilting kettle cooks as it mixes, thus improving efficiency of operation. It is obvious that combining two simultaneous operations saves both time and labor. The cooker-mixer is available in 40, 60 and 80 gallon capacities. When agitators are removed from the shafts, the kettle can then be used as a conventional stationary or tilting kettle.

Dietitians are enthusiastic about its performance and potential for mixing and cooking mashed potatoes, sauces, gravies, puddings, cereals, icings and so on.

This same manufacturer displayed a power tilting, automatic electric stainless metal, steam-jacketed kettle.

It is fully enclosed in all positions and just 36 inches in over-all height. Also shown was an electric, tilting frying pan, with stainless metal exterior. The pan has automatic controls as well as another innovation, the three-basket vegetable cooking system which can replace the conventional compartment steamer.

Another manufacturer is marketing a pressure fryer, another example of dual purpose equipment.

In the pressure fryer, raw chicken can be fried in from six to eight minutes, hamburgers in from one to two minutes, and fish in from two to three minutes.

A useful item that is related to this subject of fry-cooking is a self-contained fat filter, which doubles the service life of cooking oils and fats by removing all impurities.

This equipment works like a vacuum cleaner; it pulls all oil out of the fryer, filters it, then pumps pure oil back.

One coffee purveyor exhibited complete coffee service, including automatic brewing equipment. ■



Can you find the least expensive morale booster?

The Roylprint tray cover you see above costs about one cent. But, like a nurse's smile, its value to a patient's morale at mealtime can hardly be measured.

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Menus for October 1961

Sister Mary Reginald
Dietary Supervisor
Warner Brown Hospital
El Dorado, Ark.

1

Orange Juice
Scrambled Eggs
•
Cream of Celery Soup
Broiled Chicken
Creamed Potatoes
Asparagus
Tossed Salad
Ice Cream
•
Vegetable Soup
Roast Beef
Diced Potatoes
Carrots
Sliced Tomatoes
Fruit Cocktail

2

Apple Juice
Soft Cooked Egg, Bacon
•
Chicken Rice Soup
Lamb Chops
Creamed Potatoes
Green Beans
Coleslaw
Gelatin
•
Cream of Pea Soup
Creamed Eggs
Baked Potato
Peas
Lettuce Wedge
Applesauce

3

Grapefruit Juice
Scrambled Egg, Sausage
•
Cream of Carrot Soup
Liver
Rice
Squash
Cottage Cheese Salad
Pudding
•
Chicken Noodle Soup
Sliced Chicken
Creamed Potatoes
Okra
Fruit Salad Mold
Peaches

4

Apple Juice
Scrambled Eggs
•
Cream of Celery Soup
Roast Lamb
Diced Potatoes
Wax Beans
Tomato Wedge
Pears
•
Tomato and Rice Soup
Minute Steak
Sea Shells
Beets
Lettuce Wedge
Ice Cream

5

Orange Juice
Soft Cooked Egg
•
Vegetable Soup
Meat Loaf
Rice
Peas
Orange Slices
Custard
•
Beef Noodle Soup
Lamb Chops
Diced Potatoes
Carrots
Coleslaw
Fruit Cocktail

6

Pineapple Juice
Scrambled Eggs
•
Cream of Potato Soup
Tuna Roll
Baked Potato
Green Beans
Tossed Salad
Gelatin
•
Tomato Juice
Creamed Eggs
Hash Brown Potatoes
Okra
Lettuce Wedge
Sherbet

7

Stewed Prunes
Poached Eggs
•
Asparagus Soup
Turkey Roll Sandwich
French Fried Potatoes
Squash
Sliced Tomato
Applesauce
•
Vegetable Soup
Roast Veal, Gravy
Rice
Beets
Pear in Gelatin
Ice Cream

8

Half Grapefruit
Bacon, Sweet Roll
•
Chicken Soup
Roast Turkey, Giblet
Gravy, Cranberries
Noodles
Creamed Corn
Carrots and Celery
Ice Cream
•
Cream of Potato Soup
Chicken Pot Pie
Creamed Potatoes
Beets
Lettuce Wedge
Gelatin

9

Stewed Peaches
Poached Eggs
•
Cream of Celery Soup
Baked Leg of Lamb
Diced Potatoes
Green Beans
Sliced Tomatoes
Pears
•
Vegetable Soup
Baked Fresh Ham
Baked Potatoes
Squash
Orange and Banana
Salad
Pudding

10

Grapefruit Juice
Bacon, Doughnut
•
Tomato Soup
Cubed Steak
Rice
Asparagus
Coleslaw
White Cake
•
Chicken Noodle Soup
Stuffed Green Pepper
Steamed Potatoes
Okra
Tomato Salad
Applesauce

11

Pineapple Juice
Fried Egg, Sausage
•
Mushroom Soup
Broiled Ham, Raisin
Sauce
Creamed Potatoes
Peas
Lettuce Wedge
Peaches
•
Cream of Carrot Soup
Lamb Chops
Diced Potatoes
Wax Beans
Tomato Wedge
Jam Squares

12

Orange Juice
Scrambled Egg, Bacon
•
Tomato Juice
Meat Patties
Noodles
Carrots
Pickled Beets
Fruit Gelatin
•
Celery and Carrot Sticks
Wild Duck, Rice
Dressing
Baked Potato
Squash
Cottage Cheese Salad
Baked Apple

13

Stewed Apples
Poached Eggs
•
Cream of Pea Soup
Stuffed Bass
Whipped Potatoes
Spinach
Sliced Tomatoes
Rice Pudding
•
Shrimp Cocktail
Tuna Casserole
Parslied Potatoes
Green Beans
Lettuce Wedge
Sherbet

14

Apple Juice
Scrambled Egg, Bacon
•
Cream of Tomato Soup
Lamb Chops
Steamed Potatoes
Beets
Tossed Salad, French
Dressing
Pears
•
Chicken Noodle Soup
Country Fried Steak
Asparagus
Grapefruit-Orange
Salad
Applesauce

15

Tomato Juice
Sweet Roll, Sausage
•
Mushroom Soup
Chicken Loaf
Creamed Potatoes
Green Beans
Tomato Salad
Lemon Cookies
•
Asparagus Soup
Pot Roast With
Vegetables
Baked Potato
Tossed Salad, 1000
Island Dressing
Jam Squares

16

Applesauce
Fried Eggs
•
Cream of Celery Soup
Prime Rib of Beef
au Gratin Potatoes
Carrots
Waldorf Salad
Peaches
•
Turkey Noodle Soup
Meat Patties
Noodles
Peas
Cabbage-Raisin Salad
Frozen Strawberries

17

Banana Slices
Scrambled Egg, Bacon
•
Vegetable Soup
Lamb Chops
Sea Shells
Wax Beans
Coleslaw
Peach Salad
Fruit Cocktail
•
Carrot Soup
Roast Chicken, Dressing
Creamed Potatoes
Squash
Orange-Banana Salad
Bread Pudding

18

Prune Juice
Scrambled Egg, Doughnut
•
Potato Soup
Chicken Pie
Rice
Creamed Peas
Lettuce Wedge
Lime Frost
•
Cream of Tomato Soup
Minute Steak With
Bacon Strips
Diced Potatoes
Asparagus
Cottage Cheese Salad
Lemon Chiffon Pudding

19

Stewed Apples
Sweet Roll
•
Chicken Noodle Soup
Salisbury Steak
Baked Potato
Beets
Orange-Banana Salad
Chocolate Cake
•
Beef Broth
Roast Beef, Gravy
Whipped Potatoes
Okra
Cranberry Salad
Gelatin

20

Apple Juice
Scrambled Eggs
•
Onion Soup
Baked Fish
Diced Potatoes
Spinach
Coleslaw
Custard
•
Tomato Juice
Baked Tuna
Noodles
Creamed Carrots
Tomato Salad
Sherbet

21

Stewed Peaches
Fried Egg, Bacon
•
Cream of Asparagus
Soup
Meat Loaf, Rice
Stuffed Celery and
Cheese
Green Beans
Fruit Cocktail
•
French Onion Soup
Lamb Chops
Steamed Potatoes
Beets
Orange-Banana Salad
Marble Cake

22

Half Grapefruit
Soft Cooked Egg
•
Mushroom Soup
Roast Chicken
Creamed Potatoes
Peas
Tomato Salad
Ice Cream
•
Chicken Noodle Soup
Roast Pork
Diced Potatoes
Squash
Tossed Salad, 1000
Island Dressing
Boysenberry Crisp

23

Stewed Apple
Fried Egg, Bacon
•
Bean Soup
Meat Patties
Sea Shells
Wax Beans
Cottage Cheese Salad
Chocolate Sundae
•
Vegetable Soup
Braised Beef
Baked Potato Boat
Sliced Tomatoes,
French Dressing
Peaches

24

Kadota Figs
Poached Egg, Bacon
•
Cream of Tomato Soup
Swiss Steak
Noodles
Buttered Carrots
Peach Salad
Banana Cake
•
Celery Soup
Broiled Chicken
Whipped Potatoes
French Green Beans
Orange-Banana Salad
Bread Pudding

25

Orange Juice
Sweet Roll, Bacon
•
Cream of Potato Soup
Veal Stew
Buttered Potatoes
Asparagus
Apple-Raisin Salad
Ice Cream
•
Tomato Juice
Hamburger on Bun,
Onion Slice, Pickle
French Fried Potatoes
Pickled Beets
Stuffed Prune Salad
Gelatin, Whipped Cream

26

Stewed Prunes
Scrambled Egg, Sausage
•
Cream of Chicken Soup
Country Fried Steak
Rice
Green Peas
Tossed Salad
Fruit Cocktail
•
Cream of Carrot Soup
Hot Turkey Sandwich
Diced Potatoes
Squash
Molded Fruit Salad
Applesauce

27

Grapefruit Juice
Sweet Roll
•
French Onion Soup
Salmon Steaks, Lemon
Butter
Creamed Potatoes
Spinach
Coleslaw
Jam Squares
•
Cream of Pea Soup
Baked Halibut
Baked Potato
Green Beans
Tomato Salad
Sherbet

28

Pineapple Juice
Poached Egg
•
Vegetable Soup
Baked Pork Chop
Noodles
Carrots
Jellied Fruit Salad
Applesauce
•
Alphabet Soup
Meat Patties
Parslied Potatoes
Beets
Wilted Lettuce
Orange Banana Salad
Cherry Cobbler

29

Half Grapefruit
Scrambled Egg, Bacon
•
Cream of Chicken Soup
Roast Turkey
Creamed Potatoes
Peas and Carrots
Pickles, Olives, Celery
Pear Salad
Ice Cream
•
Pepper Pot Soup
Sliced Chicken
Steamed Potatoes
Fruit Salad
White Cake

30

Apple Juice
Poached Eggs, Bacon
•
Cream of Celery Soup
Liver
Rice
Green Beans
Lettuce Wedge
Sliced Apricots
•
Vegetable Soup
Meat Patties
Diced Potatoes
Squash
Pineapple Salad
Chocolate Sundae

31 Stewed Prunes, Doughnut, Sausage • Onion Soup, Minute Steak, Whipped Potatoes, Beets, Grapefruit Salad, Baked Apple • Chicken Noodle Soup, Broiled Chicken in Orange Sauce, Wax Beans, Waldorf Salad, Stuffed Prune Salad, Peach Meringue.

Ready-to-eat or cooked cereal served on all breakfast menus.

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does
a lot
for people



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This electronic communication system takes the strain off an overburdened switchboard and increases the efficiency of patient care

Electronics Answers a Telephone Problem

Arthur L. Stern

DOCTOR calling doctor, nurse calling pharmacist, operating room supervisor calling central supply — these and dozens of other interdepartmental communications are the calls that tie up a hospital switchboard and make it almost impossible, at times, for outsiders to call in. Yet all these staff-to-staff communications are necessary to the care of patients, as a recent study at Grace-New Haven Hospital, New Haven, Conn., showed. This study also indicated that the audio-visual nurse call system at Grace-New Haven was used as much for communication between staff members as it was for conversations between patients and nurses.

Mr. Stern is administrator, Kings Highway Hospital, Brooklyn, N. Y.

In most hospitals the outside telephone system must take care of all communication needs. The weakness of this system is that a heavy flow of inside calls will inevitably interfere with calls coming into and going out of the hospital. Since many telephone extensions will be busy with internal communications, a large percentage of outside calls are unable to get through.

This was the situation at the Kings Highway Hospital, where a single position switchboard handled both outside telephone calls and internal communications among departments. As a result of the volume of inside and outside calls, our telephone lines were blocked much of the time, particularly during the normal workday from 7 a.m. to 5 p.m.

The obvious solution seemed to be to install a larger switchboard. We realized, however, that this would be a costly proposition in terms of equipment rental and additional labor cost. An automatic switchboard would also involve a costly equipment rental. And, in either case, one essential difficulty would remain: People who are using their telephones for internal conversations cannot be reached for outside calls.

To determine how we might relieve the traffic load at the switchboard and, at the same time, improve the flow of communication into and out of the hospital, we made a simple survey of the communications



Photograph courtesy Executone Inc., New York

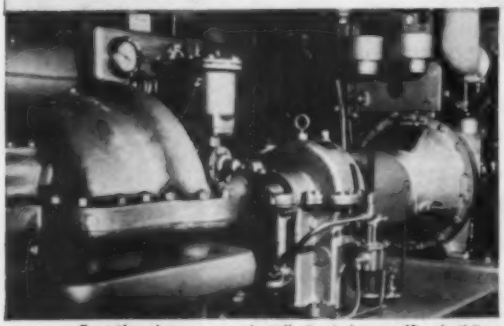
Pharmacist receives order for drugs from charge nurse. "No-hands" operation lets him receive and reply without stopping work.

Milwaukee Gas Light Company building air-conditioning powered by Waukesha.

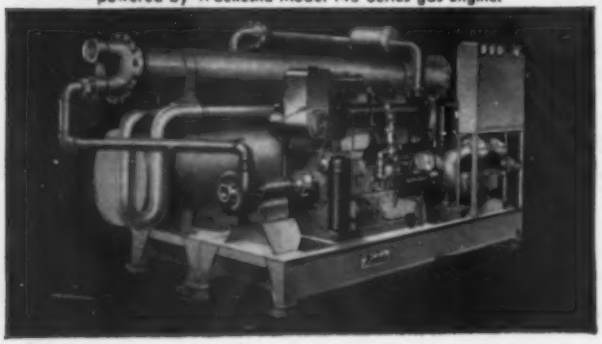
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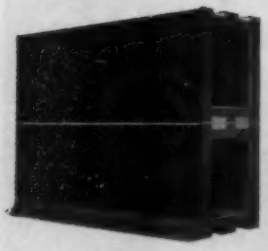
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traffic through the switchboard for a one-month period.

We hoped that the information we gathered about communication between departments would help us determine whether or not the switchboard load could be lessened by supplementing the telephone system with an independent interdepartmental communication system.

Our procedure was to request supervisory personnel to record each internal call on a simple form, indicating the time period and the purpose of the call, whether "to render service to patients," "for the operation of department," or "other."

The results (see Tables 1 and 2) indicated that much of the switchboard congestion was caused by a heavy load of internal communication traffic. These internal calls prevented the switchboard operator from performing her primary function of handling outside telephone calls and also tied up telephones, making it impossible for outsiders to reach the persons they wanted.

TABLE 1 — ANALYSIS OF INTERNAL SWITCHBOARD TRAFFIC

DEPARTMENT	% OF CALLS REQUIRING SERVICE TO PATIENTS	% OF CALLS REQUIRED TO OPERATE DEPARTMENT	PERSONAL AND OTHER CALLS
Administrator's office	11.8	77.3	11.5
Dietary	95.3	4.7	—
Maintenance	80.0	20.0	—
Radiology	68.8	22.2	9.0
O. R. supervisor	78.2	21.8	—
Nursing office	35.3	62.5	12.2
Medical records	29.5	70.5	—
Accounting	12.9	81.0	6.1
First floor nursing station	61.4	35.0	3.6
Second floor nursing station	80.0	16.0	4.0
Admitting office	62.1	23.5	14.4
Central supply	85.7	14.3	—
Pharmacy	96.0	3.1	0.9
Laboratory	79.0	19.0	2.0

This analysis of the purpose of internal telephone calls indicated that by far the majority were essential to carry out patient care or for over-all operation of the hospital.

TABLE 2 — COMMUNICATION TRAFFIC FLOW, TWO-WEEK PERIOD

CALLS ORIGINATED BY	7 A.M. — NOON	NOON — 5 P.M.	5 P.M. — MIDNIGHT	MIDNIGHT — 7 A.M.	TOTAL
Administrator's office	151	270	14	0	435
Dietary	48	22	1	0	71
Maintenance	0	0	0	0	0
X-Ray	16	21	0	0	37
O.R. supervisor	133	53	0	0	186
Nursing office	180	179	12	0	371
Medical records	0	0	0	0	0
Accounting office	57	51	0	0	108
First floor nursing station	183	107	20	0	310
Second floor nursing station	168	151	35	3	357
Admitting office	101	38	0	0	139
Central supply	0	0	0	0	0
Pharmacy	82	48	0	0	130
Laboratory	68	44	2	0	114
TOTAL	1187	984	84	3	2258

Further study of the pattern of internal communications over a two-week period served to pinpoint the times of and the departments originating the majority of calls.

Inasmuch as the largest percentage of these internal calls involved service to patients and departmental operation (see Table 1), it was clear that the telephone congestion was affecting both patient care and the over-all operation of the hospital.

The study also revealed that the heaviest volume of internal communication occurred during the normal workday (see Table 2). Further observations made during the day indicated that each of the departments involved in the study recorded a considerable amount of idle time because of busy telephone extensions.

As a result of this study, it became clear that our telephone switchboard could not handle both inside and outside calls. After surveying the many types of independent internal communication systems that were available, we decided to install an electronic communication system in the departments studied.

Master stations, enabling users to call one another at the touch of a button, were installed in all areas. Incoming calls are registered by a soft chime and a signal light. The person called may answer from anywhere in the room without leaving his work to touch or approach the station. The system also protects the privacy of the callers by making it impossible for anyone to listen in on private conversations taking place in offices where the stations are located.

The separate internal communication system, which has been in service for more than a year, has resulted in a sharp reduction in switchboard traffic and a marked improvement in both internal and external communications. Our single position switchboard now handles all outside calls.

The independent communication system cost us $3000, including installation. This compares to an annual cost of $5,277.75 if we had expanded the telephone system to handle both inside and outside calls. (This figure includes rental and additional personnel costs.) Thus, the independent system paid for itself in less than one year. And the extra benefits in terms of better patient care and more effective administration further enhance the value of a separate intercommunication system at Kings Highway Hospital. ■

How To Match Employes With Their Jobs

Continuing the series of lectures on

Administrative Housekeeping for Institutions

Mildred L. Chase

IN THE first part of this chapter on personnel relations, we discussed the importance of "humanics" in the administrative housekeeper's approach to personnel policies. (See The MODERN HOSPITAL, August.)

This section will be devoted to an analysis of the specifics of procuring employes and matching the individual to the job.

Procurement

Methods used by personnel director or department head:

1. Through present employes: Will not recommend people who do not meet requirements. Will help make newcomer acquainted. Wish to show their ability to the ones responsible for their jobs. Builds morale in knowing they helped.

2. Through the United States employment office: Must make definite qualifications known. Sometimes necessary to talk with interviewer.

3. Through agencies and institutions: Private agencies can sometimes give help. Other institutions who lose good employes because of illness, transportation or moving.

4. Advertisements: Newspapers sometimes bring more floaters. Professional journals.

5. Student help: Summer relief.

6. The walk-ins.

Mrs. Chase is director of housekeeping services, Glendale Sanitarium and Hospital, Glendale, Calif., and director of the housekeeping course at Los Angeles Metropolitan College of Business.

Screening

An interview should determine:

1. Physical condition: Hearing can be judged by asking a question in a low tone. Eyesight is sometimes noticed while filling in application. Crippling disability or deformity that might hinder in work. Obesity should be considered if it might be dangerous. Questions about hernias or varicose veins. Mental capacity. Alcoholic tendencies. Deficiencies in height. Manners and neatness. Cleanliness.

2. Family status: Number of dependents and their ages. The reason for needing job. Who would care for children (if a mother)? Transportation.

3. Educational background: Ability to read and write. Schooling.

4. Aptitude and stability: Apparent adaptability. Observation. Manual dexterity. Honesty. Reliability.

Hiring

When decision has been made, give printed instructions.

Institutional manual.
Departmental manual.
Job description.

Orientation:

Explain work hours.

Where and when he will check in and out.

Training: (1) Who will do it. (2) Approximate time allowed. (3) Where it will be done.

To whom he is responsible: (1) Immediate supervisor. (2) Others.

Take or have employe taken on a tour.

Introduce him to other workers: (1) Manager when possible. (2) Supervisors including one who will do training. (3) Others in the department.

Explain main policies.

Problem Solving Technic

Defining the problem:

Does it require a policy?

1. What kind of problem is it?

What element has to change, move or be removed before the problem can be tackled?

What is the "critical factor"?

Is it urgent? Timing is most important.

2. What do we have to do to solve it?

What are the expectations?

Why do we want to solve it?

What will it cost in money, material, men and time?

3. Defining expectation.

What do we hope to gain by solving problems?

Will it create additional problems?

4. What is the problem?

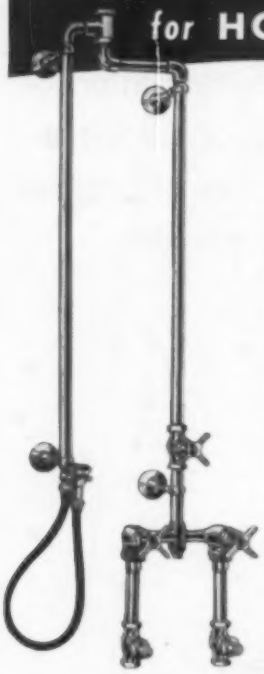
Usually all that can be seen at first are the symptoms.

"Doctoring" the symptoms while

(*Continued on Page* 164)

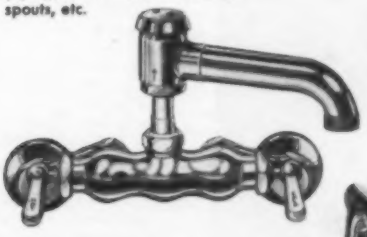
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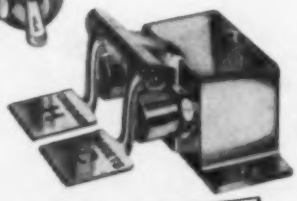


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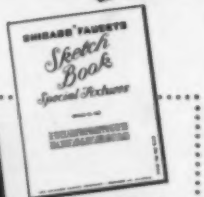
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1. Saturate swab mop.
2. Thoroughly clean under rim, working downward.
3. Flush.

Cleaning Urinals

1. Saturate mop.
2. Start at top and work down.
3. Flush.

Cleaning Stainless Steel

1. Saturate cloth or swab.
2. Wipe off surface to be cleaned.

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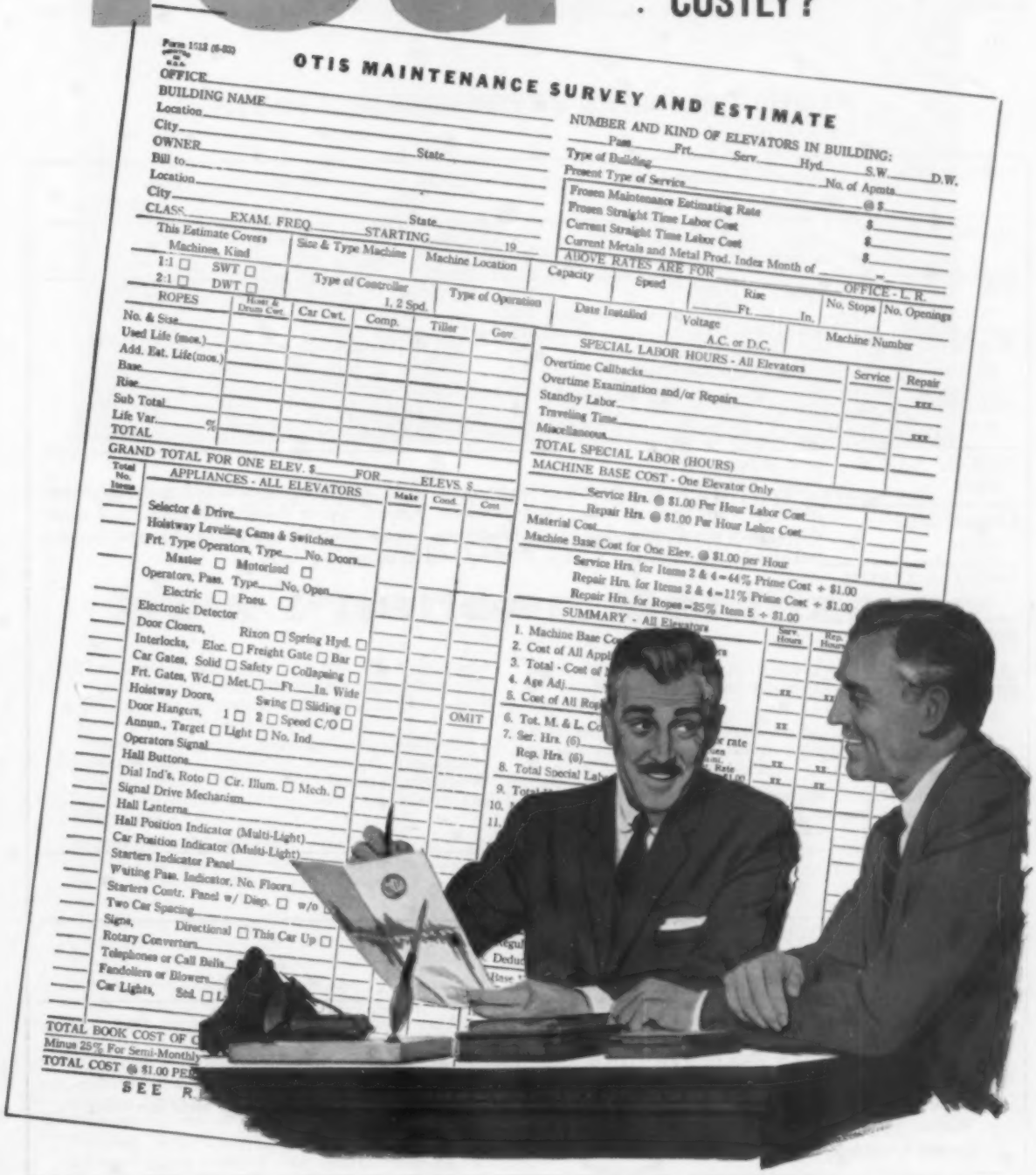


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(*Continued From Page* 160)

leaving the basic problem untouched provides only temporary relief.

By isolating the "critical factor," surface symptoms can be broken through and the real problem can be reached.

5. Timing is part of the job of defining the problem.

Don't make a decision before it can be effective.

Don't postpone a decision until it has reached a point where it has become timely.

6. Specification for acceptable solution to the problem.

What can be accomplished?

Will the decision overcome a present difficulty?

Will the decision prevent a recurrence of the crisis? (*Cont. on p.* 166)

BE SPECIFIC WHEN YOU ARE SPECIFYING REQUIREMENTS FOR A JOB

EMPLOYER	The Black Hospital	JOB TITLE	Houseman	CODE 2-24-55
ADDRESS	200 North Street Los Angeles, California	REFER TO PHONE	Mrs. Young LA 1-2345	DATE 10-1-59
SEX M	EDUCATION Speak, read, and write English	EXPERIENCE None Training time – one week		
AGE RANGE 25-65	OTHER PHYSICAL REQUIREMENTS Examination – Must be able to do the job.			
HEIGHT RANGE 5' 5" up				
WEIGHT RANGE Open	JOB SUMMARY Uses a central vacuum cleaning unit to clean 12 to 14 patient rooms and corridor. Moves furniture while cleaning room; cleans transoms, screens, top of doors, chandeliers, and mirror doors; may wash mirror doors and chandeliers; moves furniture in and out of rooms; keeps a record of rooms cleaned; reports anything broken or missing.			
CITIZENSHIP Open				
MARITAL STATUS Open				
UNION Yes				
HOURS 8 AM to 4 PM 40 hrs. 5 days				
RATE OF PAY Existing rate				
OTHER				

EMPLOYMENT FACTORS

Must be clean in appearance and a careful workman.
Must have strength of arms, back, legs and feet.

SUPPLEMENTARY FACTORS:

Uniforms:	Uniforms are furnished and laundered by employer.
Transportation:	Walk to side entrance. Ask timekeeper for housekeeper's office.
Blue Cross:	Dues are paid by employes.
Vacation:	One week vacation with pay for one year's employment; two weeks after five years.
Wages:	Time and one half over 40 hours.
Lunch:	Free lunch is available if desired.

The housekeeper who calls the personnel office and asks for a "houseman" or "maid" or whatever, without specifying the nature of the work to be done and the qualifications needed to do it, is doing herself, the personnel office, and the employe an injustice. To be effective, the job order should include all the details of the job, the physical requirements, the type of person needed, and such details as are shown on sample requisition form.



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Higher Phenol Coefficient. New PHENEEN SANITIZER has a phenol coefficient of 26 against *Staphylococcus aureus* and 16 against *Salmonella typhosa.*

Hard Water Tolerance 750 ppm. Retains active germ-killing powers in solution with hard water that deactivates other quaternaries.

Maximum Germicidal Coverage. The new formulation is effective against both gram-positive and gram-negative pathogenic and odor-forming bacteria.

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New PHENEEN SANITIZER is particularly appropriate for disinfection in hospitals, where it serves as an aid in combatting cross-infection, such as **Staphylococci.** And it aids in preventing infections in doctors' offices, homes for the aged . . . in fact any area where large numbers of people pass or gather.

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1400 Harmon Place • Minneapolis 3, Minnesota

All of the above claims are substantiated by extensive laboratory tests. Reports available on written request.

(*Continued From Page* 164)

Is the decision to be purely defensive?

Will the decision give an opportunity for growth and expansion?

Solutions to problems:

1. Combine in new ways.

Put in new context of time and place.

Add other ideas.

Take something away.

Change color, meaning or purpose.

2. Name the target.

What is the problem?

Try obvious solutions first.

Walk away from the problem.

Make use of the flash of insight. (Have note pad at bedside.)

3. Some precautions in problem solving.

Do something about the idea.

Don't tackle too big a problem — take bite-size problems.

Don't spend so much time on solving problems which are not worth solving that not enough time is spent on important problems.

4. Solve one problem at a time.

Don't worry about a handful of problems at one time.

It isn't necessary to solve a problem in one-two-three order.

Pass over parts that cannot be solved.

Go into some piece of the puzzle you can solve. Often this suggests ideas for parts you could not solve previously.

Develop alternate solutions:

1. Realize that solving one problem can cause another problem.

Never stop with a single idea.

Reduce ideas to specific terms.

Talk about your ideas (think out loud).

Keep trying; every problem is susceptible to solution.

Study total situation not only in terms of solving present problem, but preventing similar problems from arising in the future.

2. Related problems.

In working out a solution to a problem, the effect on other problems outside the situation is likely to be reviewed in some detail.

One thing to consider is why mistakes occur in the decision making process.

Many people do not organize their decision making.

Decision making must take into consideration wrong distribution of time spent. Too much time may be spent on finding the answer and not enough on identifying the problem and analyzing the existing situation.

Every decision should be an attempt to balance gains, costs and risks.

One must know what to do with the decision after it has been reached.

Decision making is always with us. We cannot get away from making decisions since making no decision is a decision, too.

Decision making should be looked upon as an opportunity as well as a problem. ■

HOUSEKEEPING CALLS FOR PHYSICAL FITNESS

The following check list is useful in assessing the employe's physical fitness with respect to the tasks he will be expected to perform and the physical conditions under which he will work.

Physical Activities		Working Conditions	
Walking	Kneeling	Inside	Odors
Jumping	Sitting	Outside	Noisy
Running	Reaching	Hot	Adequate lighting
Balancing	Lifting	Cold	
Climbing	Carrying	Sudden temperature change	Vibration
Crawling	Throwing		Adequate ventilation
Standing	Pushing	Humid	
Turning	Pulling	Dry	Mechanical hazards
Stooping	Handling	Wet	
Crouching	Fingering	Dusty	Moving objects
Feeling	Talking	Dirty	Cramped quarters
Hearing	Seeing	Electrical hazards	
Color vision	Depth perception	Radiant energy	High places
Working speed		Working with others	Exposure to burns
		Working alone	Explosives
			Toxic conditions
			Working around others

Details of Physical Activities:

No time is mentioned as the physical activities vary with the condition of the rooms and the corridor. Walks, stands, turns, stoops, climbs (up to 15 feet while balancing) and crouches while cleaning rooms and corridor. Handles paper and pencil to record rooms cleaned. Reaches for handles, lifts and pulls vacuum unit (10 lbs.) up to 10 yards to clean carpets. Reaches to grasp furniture to push and pull to move about. Lifts and carries furniture when necessary.

Details of Working Conditions:

Works alone and with others in an adequately lighted and ventilated room (6 to 7½ hours). Hands become wet when washing mirror, doors and chandeliers (½ to 2 hours). May work on a stepladder as high as 15 feet (15 minutes to 2 hours).

Details of Hazards:

Possibility of bodily injuries from falling off ladder. Possibility of cutting hands and fingers on broken glass.

Not all housekeeping employes have to be able to meet all of the physical requirements listed above, nor will their working conditions be the same in all cases. The purpose of the check list is to serve as a reminder to the housekeeper to match the prospective employe to the jobs he will perform.



Private rooms in Riverside Methodist Hospital, Columbus, Ohio, are completely equipped by Simmons. Multi-Matic beds are used throughout this new 416-bed hospital. Furniture is from Simmons' Vivant group.

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Ultra-efficient Multi-Matic beds embody the most advanced ideas in patient care. These beds are completely motorized and listed by the Underwriters' Laboratories. Eight distinct motorizing actions allow adjustments to any prescribed medical position. Safety sides store under the bed...head and foot panels are removable for traction application...solid, posture-firm mattress panels are easy to keep sanitary.

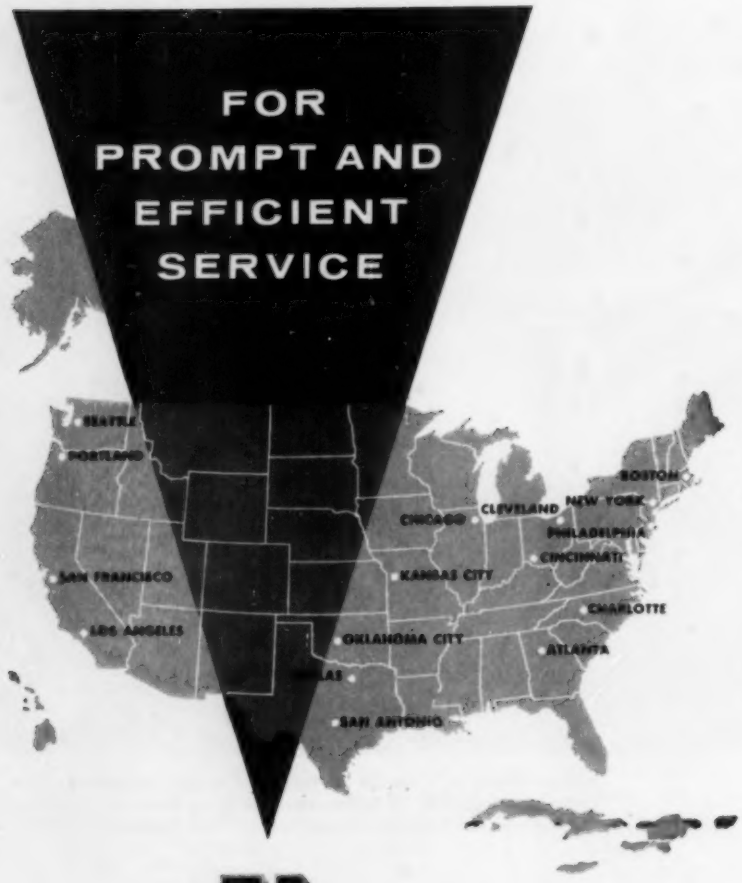
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and 15 Other Cities

Which Nurses Join Professional Organizations?

(*Continued From Page* 125)

usually associated with professionalism, such as a view of one's occupation as a life work and a strong commitment to the field (see Table 6), the members of the A.N.A. (and N.L.N.) score higher on these than do the nonmembers. In addition, a larger proportion of them view nursing as having an exclusive domain over a body of knowledge and skills. Not only are they more committed to the field but they make more effort to keep up with professional activities, are more interested in professional meetings, and believe more strongly in the need to upgrade their occupation.

Since the A.N.A. is often thought of as being more concerned with bargaining for increased economic and other benefits than in improving nursing standards, it is interesting to report that the A.N.A. members claimed equal job satisfaction and expressed less disappointment with working conditions, such as wages and hours, than did the nonmembers. (See Table 7.) The only area in which they expressed greater disappointment was in the amount of patient contact their jobs provided. It should be noted, however, that the younger nurses in both groups registered more dissatisfaction with working conditions than did the older nurses.

Implications of the Study

To the extent that the findings of this study are applicable to the field of nursing in general, they indicate that nurses who join the national nursing organizations are still a minority in the field; they are concentrated largely in the nursing schools and among the older, higher status members of the profession, and the membership is concerned with its professional responsibilities to the field.

As the nursing organizations are able to involve more of the nurses who are now in practice, and continue to work toward higher standards of performance through research and improvement of their educational programs, they can be expected to help raise the standards of medical care in our hospitals to an even higher level. ■

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Bronx Hospital, Bronx, N. Y.
Vanderbilt University Hospital, Nashville, Tenn.
City Hospital of Akron, Akron, Ohio
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MH-961

What Consent Forms Do Hospitals Need?

(*Continued From Page* 119)

mission. Then both consent forms should be prepared and signed at the same time. Otherwise, the special consent form is to be signed at the time the contemplated procedure is explained to the patient by his physician.

Since some of the language on the special consent form and the admission consent form are identical, only those paragraphs in which the special consent form differs will be commented upon.

One such difference is that the special consent form contains a place for recording the time consent is given. *Exact time of consent is important.* It provides evidence that consent was procured at a time when the patient was competent to sign the consent form, and not under preoperative sedation. The exact time is particularly important when the form is signed on the same day the procedure is carried out, for in such instances there is an inference that the patient was not competent to consent at the time he did so.

Paragraph 1. A space is provided so that the precise procedure can be listed on the form. If a second operation becomes necessary, a separate consent form should be procured. This renders it unnecessary to attempt to prove that authority to undertake the second procedure was implied from consent to the first. If a series of similar procedures is indicated, the series can be listed when consent is first given, thus procuring consent to the entire course of treatment at one time.

Paragraph 2. Naming the physician who explained the contemplated procedure to the person signing the form reinforces the statement that an explanation took place. Placing the burden of explanation upon the attending physician is consonant with the physician-patient relationship and guarantees that the procedure will be explained by one competent to do so. At no time should such an important requirement as the explanation of the procedure be left in the hands of a nurse or the admissions clerk. The explanation must include the nature of possible consequences of the procedure so that the patient understands the attendant risks. As part of this explanation, the procedure should be described in terms of what will be done to the patient and what the consequences will be. The description written on the consent form should be stated in simple words, understandable to the layman, rather than in technical terminology. This written explanation of the procedure provides added proof that the patient understood the nature and consequences of the procedure.

Paragraph 3. This paragraph is inserted to negate the contention that the physician is limited to the exact scope of the procedure described in Paragraph 2. This general language will cover an extension, alteration or modification of the original procedure without the necessity of relying upon any implied consent.

Paragraph 4. Consent to use of anesthesia protects the hospital from the possibility that the patient may contend that he did not consent to the use of a certain type of anesthesia.

Paragraph 7. This paragraph number has been placed on the form to show the location for insertion of a paragraph providing consent to a procedure which involves experimental drugs or technics. When an experimental operation, drug or technic is contemplated, the following language should be inserted in Paragraph 7.

"I understand that the procedure designated and explained in Paragraph 2 above is an experimental one, that it involves more than ordinary risks, and that the consequences of its use cannot be predicted. With full knowledge of this, I consent to its use upon me and assume all risks for harmful results, releasing Dr. .. .., the ..... Hospital and their nurses and technicians from liability for its use."

I cannot stress too strongly that hospitals need to utilize the special consent forms when a surgical procedure is indicated. There has been a great increase in the number of judicial decisions involving consent in the last three years. Courts look much more closely at the exact wording of the forms being used. While hospitals have sufficient routine work already, this form does not add appreciably to that burden. And, the use of this form will provide protection to the hospital in a situation where lack of provable consent could result in a large verdict against the institution. ■

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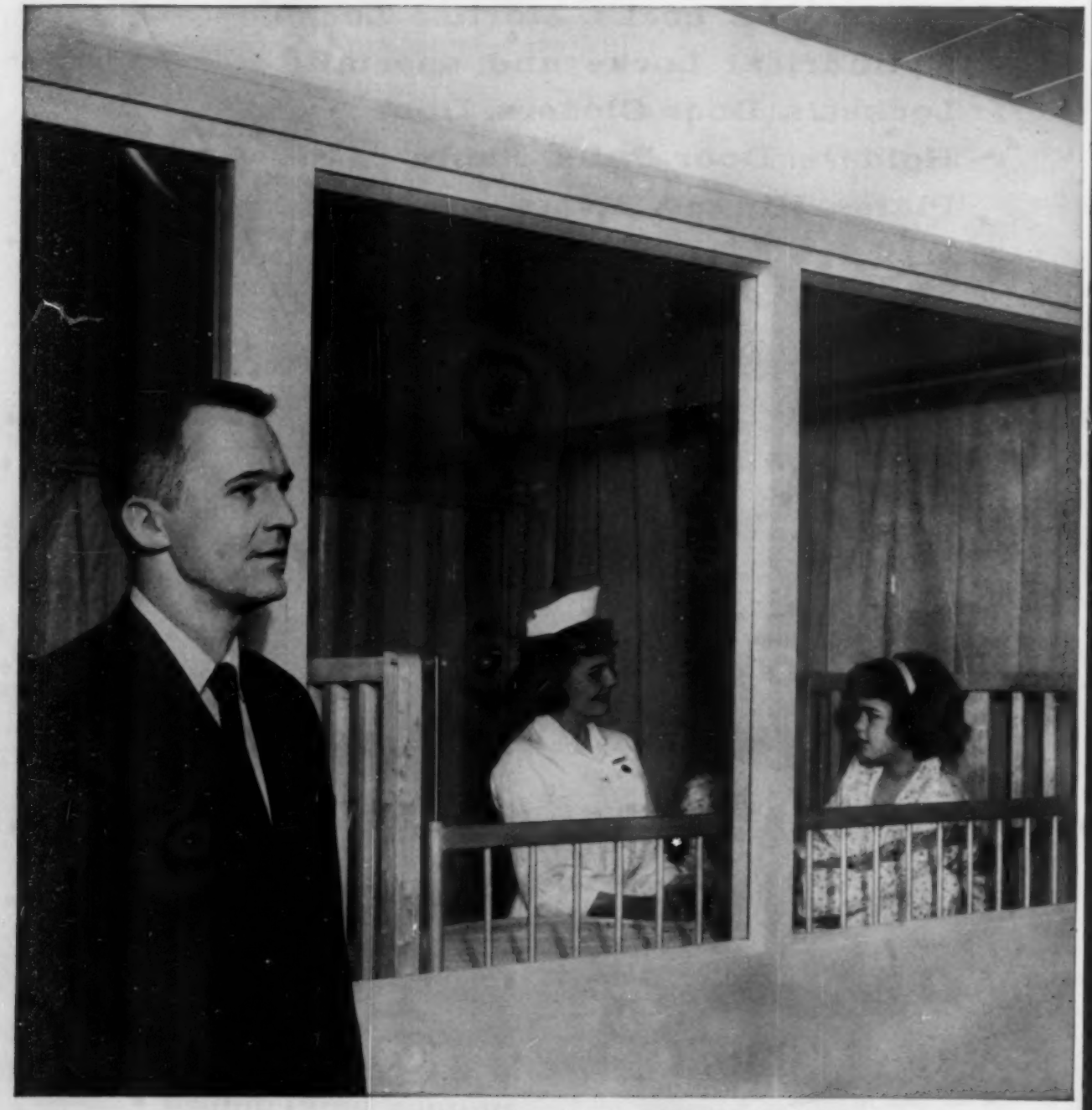
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The Modern Hospital News Digest

Milwaukee Union Takes Control of Hospital; Plans To Start a Medical Center for Members

MILWAUKEE. — Control of Capitol Hospital here has been seized by a labor union, which intends to use it as the nucleus of a cooperative medical center.

The hospital, a 36 bed voluntary institution begun in 1952, was taken over by District Council 48 of the American Federation of State, County and Municipal Employes, an A.F.L.-C.I.O. union.

John C. Zinos, executive director of the union, took control with the cooperation of the president of the hospital's board of directors, Maxwell Hughes, and Mr. Hughes' wife, who also was on the board. Mr. Hughes said he was motivated by a desire to save the hospital; its tax exempt status has been revoked by the federal government retroactive to 1951, owing to activities of the former medical director, Dr. Milton Margolies, now serving a federal prison term for personal income tax evasion.

Mr. Zinos and the board's new counsel, Max Raskin, a labor lawyer, have been working to convince the government that tax exempt status should be restored. Otherwise, the new management may find itself with a tax debt estimated at $195,000. The building has been appraised at $225,000, but is mortgaged for $108,000.

Initially, the union intends to operate a low-cost cooperative pharmacy, using the hospital as a headquarters and setting up branches. There are about 120,000 potential union members encompassed in the plan. With dependents, the total would be 400,000.

Eventually, it is planned to set up a comprehensive medical center, staffed by a panel of doctors, to provide care to union members at the expanded hospital. Mr. Zinos said he hoped that present Blue Cross-Blue Shield contracts could be used in the interim. ■

State Officials Attack K.C.'s 'Disguised' Nursing Homes

KANSAS CITY, MO. — The state attorney general and health director have launched an attack on Kansas City's "bootleg" nursing homes.

Long a sore point with licensed nursing home operators in the state, inspection of so-called "boarding" homes has been denied state officials. Under present statutes and regulations, they have no authority to enter suspected illegal homes that hide their ill and aged patients under the guise of boarding homes.

Surprise visits by the attorney general and the state health director in person on August 13 gained them entry to 16 Kansas City boarding houses. Injunctions were filed against five persons for operating nursing homes without licenses.

The Missouri Division of Health has been trying to persuade the city council of Kansas City that it should set up an inspection program for homes. The council has not accepted the suggestion, passing it back to the state, which officially can do nothing about it until an operator applies for a nursing home license.

Employes Postpone Strike, But Refuse Hospital Offer

OAKLAND, CALIF. — Employes of seven hospitals here have postponed a threatened strike, but apparently are no nearer agreement.

According to *Services Labor Report*, the Hospital and Institutional Workers union refused to accept a two-year agreement proposed by the Associated Hospitals of East Bay.

A union spokesman termed "wholly unacceptable" an offer to raise wages by $5 a month this year, and $5 more July 1, 1962. Among the union's demands are arbitration of grievances, a union shop, higher night differentials, and disability insurance.

Hospital employes are now working on a day-to-day basis while negotiations continue, the report said.

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(*Continued From Page* 110)

Section 5. Upon receipt of a written authorization in proper form from the employe, the Employer agrees to deduct from the employe's wages all dues and initiation fees as certified to the Employer by the Union; such monies shall be remitted bi-weekly to the Milwaukee County District Council #48, AFSCME, AFL-CIO, Union Dues Trust Account.

Section 6. The Union security provisions hereof are made possible because of a favorable vote by the employes in an all-union referendum held by the Wisconsin Employment Relations Board on June 11, 1959.

ARTICLE III

Wages.

Section 1. See Wage Schedule attached.

Pay Periods.

Section 2. All wages shall be paid on the basis of two-week periods.

Premium Conditions.

Section 3. It is understood that the provisions of this contract relating to hours, wages and working conditions are intended to establish minimum terms for the hiring of employes subject to this contract; that so long as the Employer meets these minimum terms with respect to such employment it has fully performed its obligations under this contract; and that this contract is not intended to preclude or discourage the hiring of employes under terms more favorable to them and accordingly, if any employes are hired under more favorable terms, this shall be a matter of individual arrangement with such employes and such arrangements may be established, eliminated or changed at any time without relation to this contract.

Equal Pay.

Section 4. There shall be no distinction between the wages paid to men and the wages paid to women for the performance of comparable quality and quantity of work on the same or similar operations.

Uniforms.

Section 5. When any change of uniforms takes place among employes who are required to wear uniforms, the Employer shall furnish three (3) new uniforms to all employes affected by such change.

Combination Jobs.

Section 6. Any employe who (1) as a part of his regular predetermined work schedule, or (2) in the course of a vacation relief assignment, relieves another employe in a higher classification, shall be paid at a rate which shall compensate him at the rates for the different classifications in ratio to the time spent in each at the rate of pay equivalent to his seniority.

(*Continued on Page* 178)

Minimum Wage Rates at Mount Sinai Hospital

Effective March 1, 1961 - February 28, 1962

	START	6 mos. - 1 yr.	1-5 yrs.	over 5 yrs.
BUILDING SERVICE				
Maintenance Mechanics	2.05	2.10	2.23	2.36
Carpenters	1.90	1.95	2.08	2.20
Utility Man	1.75	1.80	1.93	2.05
Maintenance Helper	1.70	1.75	1.88	1.99
Yard Man	1.50	1.55	1.68	1.78
Houseman	1.32	1.37	1.50	1.59
Head Unit Maid	1.22	1.27	1.40	1.48
Maid	1.09	1.14	1.27	1.35
Elevator Operator	1.12	1.17	1.30	1.38
LAUNDRY				
Extractor - Wash Man	1.50	1.55	1.68	1.78
Presser & Folder	1.20	1.25	1.38	1.46
Feeder	1.15	1.20	1.33	1.41
Shaker & Sorter, Tumbler Helper	1.10	1.15	1.28	1.36
DIETARY				
1st Cook	1.55	1.60	1.73	1.83
Night Cook	1.34	1.39	1.52	1.61
2nd Cook	1.34	1.39	1.52	1.61
Kitchen Mechanic	1.32	1.37	1.50	1.59
Janitor	1.32	1.37	1.50	1.59
Personnel Food Supervisor	1.26	1.31	1.44	1.53
Ass't Personnel Food Supervisor	1.22	1.27	1.40	1.48
Patient Food Supervisor	1.22	1.27	1.40	1.48
Cartman	1.15	1.20	1.33	1.41
Food Service Employee	1.09	1.14	1.27	1.35
LABORATORY				
Laboratory Aide	1.32	1.37	1.50	1.59
NURSING				
Nurse's Aide	1.15	1.20	1.33	1.41
Orderly	1.32	1.37	1.50	1.59

Effective March 1, 1962 to October 31, 1962

	START	6 mos. - 1 yr.	1-5 yrs.	over 5 yrs.
BUILDING SERVICE				
Maintenance Mechanics	2.13	2.18	2.31	2.45
Carpenters	1.98	2.03	2.16	2.29
Utility Man	1.78	1.83	1.96	2.08
Maintenance Helper	1.73	1.78	1.91	2.02
Yard Man	1.58	1.63	1.76	1.87
Houseman	1.35	1.40	1.53	1.62
Head Unit Maid	1.25	1.30	1.43	1.52
Maid	1.12	1.17	1.30	1.38
Elevator Operator	1.15	1.20	1.33	1.41
LAUNDRY				
Extractor-Washer	1.58	1.63	1.76	1.87
Presser & Folder	1.23	1.28	1.41	1.49
Feeder	1.18	1.23	1.36	1.44
Shaker, Sorter, Tumbler, Helper	1.13	1.18	1.31	1.39
DIETARY				
First Cook	1.58	1.63	1.76	1.87
Night Cook	1.37	1.42	1.55	1.64
Second Cook	1.37	1.42	1.55	1.64
Kitchen Mechanic	1.35	1.40	1.53	1.62
Janitor	1.35	1.40	1.53	1.62
Personnel Food Supervisor	1.29	1.34	1.47	1.56
Ass't. Personnel Food Supervisor	1.25	1.30	1.43	1.52
Patient Food Supervisor	1.25	1.30	1.43	1.52
Cartman	1.23	1.28	1.41	1.49
Food Service Employee	1.12	1.17	1.30	1.38
LABORATORY				
Laboratory Aide	1.35	1.40	1.53	1.62
NURSING SERVICE				
Nurse's Aide	1.18	1.23	1.36	1.44
Orderly	1.35	1.40	1.53	1.62

Tests of hospital linen show . . .

99.5% reduction in Staph count of soiled linens when SWIFT'S ENSTAPH is used

In tests conducted at five Chicago area hospitals, it was found that the use of ENSTAPH resulted in a 99.5% reduction in the *Staphylococcus* count of urine soaked diapers.

The diapers from hospitals using no germicides in their washing formulas showed an average *Staphylococcus* count of 5,460,000 per diaper—hospitals using ENSTAPH average only 25,200.

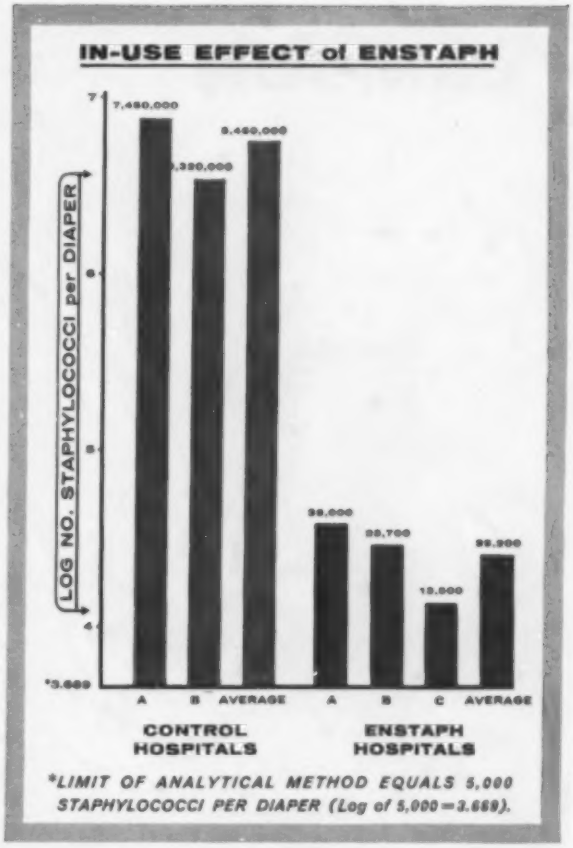
CONCLUSIONS

The results show the hazard that is created when linens soiled with fluids are held at temperatures permitting bacterial growth. *Staphylococcus* contaminated material becomes a focus of infection to the patient and *to the environment*, thereby to all patients and personnel. The regularity with which *staphylococci* can be found in soiled linens shows that the danger of an outbreak always exists.

THE ROLE OF ENSTAPH

Swift's ENSTAPH breaks the cycle of *Staphylococcus* transmission in linens. Fabric washed in ENSTAPH is impregnated with germicides which inhibit *Staphylococcus* growth at levels as low as 1 to 2 parts per million. Linens retain their anti-bacterial characteristics during dry storage. During use, when the cloth is moistened, the germicides are activated and exert their activity against contaminating *staphylococci*.

Our studies have shown that unprotected linens constitute a potential threat to the hospital environment. The use of ENSTAPH presents a solution to this problem. The hospital must decide whether it can afford to treat its linens with germicides in order to break the cycle of *Staphylococcus* transmission.



LET'S LOOK AT THE FACTS ABOUT COST AND USE

ENSTAPH adds 2¢ to 3¢ to the cost per hundred pounds of dry linens washed. It is as easy to use as ordinary washing materials because it is a completely built quality soap containing a germicidal system. ENSTAPH goes into the wash wheel just as it comes from the drum. No special formulas, additives or procedures are required. With the protection afforded at 2¢ to 3¢ per hundred pounds of dry linens, can the hospital afford *not* to use ENSTAPH?

ADDITIONAL INFORMATION

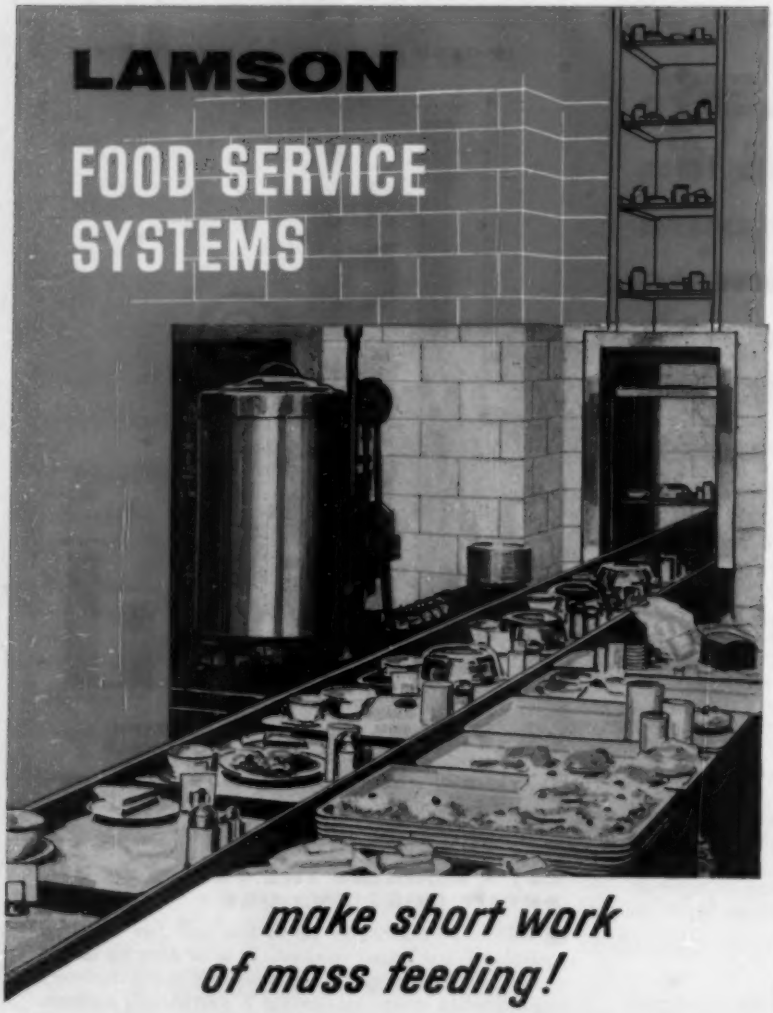
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(*Continued From Page 176*)

ARTICLE IV

Hours of Work.

Section 1. Forty (40) hours shall constitute the work week, eight (8) hours per day, five (5) days per week. All work in excess of eight (8) hours per tour of duty or in excess of forty (40) hours per week shall be paid for at one and one-half (1½) times the employe's basic hourly rate, provided, however, that overtime pay shall not be pyramided. Any employe called in to work on his regular day off shall receive two dollars ($2) in addition to wages otherwise payable under this Agreement.

Overtime.

Section 2. Overtime will be equalized among employes holding the same job assignment, or the same multiple assignment insofar as is reasonable and practical in accordance with the requirements of the job and the ability of the employes.

Employes are expected to cooperate with management in working overtime in case of emergency but no employe shall be discriminated against or disciplined for his individual inability to work overtime.

Work After 7th Consecutive Day.

Section 3. All work after the seventh (7th) consecutive day of work shall be paid for at the rate of one and one-half (1½) times the basic hourly rate.

Definition of Tours.

Section 4. A straight tour is defined as a regular day's work of eight (8) hours completed within nine (9) consecutive hours with not more than one (1) hour for lunch. A split tour is defined as eight (8) hours completed within the spread in excess of nine (9) consecutive hours.

Split Tour Premium.

Section 5. All employes performing work on a split tour completed within the spread of more than nine (9) hours shall be paid a premium of ten (10) cents per hour above their regular rate of pay.

Night Tour Premium.

Section 6. The full-time night tour which commences at or after 10:30 o'clock p.m. and ends prior to 7 o'clock a.m. shall entitle any employe who works such night tour to a pay differential of five (5) cents per hour above their regular rate of pay.

Rest Periods.

Section 7. All employes shall be granted a rest period of fifteen (15) minutes during each half tour without deduction of pay.

Section 8. Any employe required to work in excess of three (3) consecutive Sundays shall receive a premium of $3 for that day.

ARTICLE V

Vacations.

Section 1. All employes covered by

this Agreement who are regularly scheduled to work at least forty (40) hours per week and who have been continuously employed for a period of one year shall be entitled to ten (10) working days (80 hours) vacation with pay and fifteen (15) working days (120 hours) vacation with pay after five (5) years of continuous service. The anniversary date will be used as the base period.

The vacation pay shall be equal to the regular straight time pay, and there shall be added the tour premium, if any, provided for work on the regular tour the employe was scheduled to work.

Section 2. Vacations for employes who are regularly scheduled to work less than forty (40) hours per week, but at least twenty (20) hours per week, shall be determined the same as for employes included under Section 1, but shall be pro-rated on the basis of hours regularly scheduled. To be eligible for vacations such employes must work the regular schedule of the department—take normal turn on week ends and holidays. No vacations shall be granted to employes regularly scheduled to work less than twenty (20) hours per week.

Section 3. If an employe is otherwise eligible for ten (10) days of vacation, one (1) day of vacation shall be deducted for each twenty-six (26) days that he was absent from work on his regularly scheduled working days during the twelve (12) months preceding his anniversary date for any reason except paid sick leave or occupational illness or injury. If an employe is otherwise eligible for fifteen (15) days of vacation, one and one-half (1½) days of vacation shall be deducted for each twenty-six (26) days that he was absent from work and on his regularly scheduled working days during the twelve (12) months preceding his anniversary date for any reason except paid sick leave or occupational illness or injury.

Section 4. The employe shall receive his vacation pay on the pay day immediately preceding his vacation, provided he makes a written request to his immediate supervisor at least two (2) weeks before going on vacation.

Section 5. Whenever practicable employes shall be given preference on the basis of seniority, but vacation schedules must be approved by the supervisor and department head. Vacations are not to be scheduled between November 15 and January 15 unless otherwise agreed to by the Employer and the employe.

Section 6. If a holiday as set forth in Article VI occurs during the employe's vacation period, he shall be granted an additional day of vacation with full pay.

Section 7. An employe (or his estate) who, after giving two weeks' notice, quits or retires, or dies will receive the pro-rata vacation allowance to which he may then be entitled. An employe who is discharged for cause or who fails to give at least two weeks' advance notice of quitting shall not be entitled to vacation.

Section 8. An employe eligible for two or more weeks' vacation may split his vacation into separate weekly periods.

ARTICLE VI

Holidays.

The following six (6) holidays are designated as paid holidays for all employes covered by this Agreement: New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, and Christmas Day. Any employe not scheduled to work on any such holiday shall receive pay at his regular straight time rate for his regularly scheduled number of hours provided that he works the last scheduled workday preceding and the first scheduled workday following such holiday. Any employe required to work on any such holiday shall receive a day off, with pay computed on the same basis, at a later date at the convenience of such employe and the Employer.

ARTICLE VII

Sick Leave

Section 1. A paid sick leave allowance for all employes covered by this Agreement shall accrue at the rate of one (1) day for each month of service to a maximum of 45 days. Sick leave taken by the employe is applied against the sick leave allowance accrued and the difference is the unused sick leave allowance. Paid sick leave will be allowed only in case of actual illness. The employer may send its own physician or registered nurse to visit any employe on sick leave at any time or request that the employe furnish a doctor's certificate. The compensation of regular part-time employes shall be computed according to their regularly scheduled number of hours of employment per week in the particular employe's classification.

Section 2. Each employe will be allowed four (4) days of accrued sick leave as one day or first day illnesses during each year as of March 1, 1961, or anniversary date if hired after March 1, 1961. When such four first days have been exhausted any future illnesses during the twelve month period that amount to three days or less will be charged to accrued sick leave with the exception of the first day of illness, which will not be paid sick leave.

If the absence due to illness extends beyond three (3) consecutive days and the employe has accrued sick leave due, the first day is included as paid sick leave and is not counted as a first day illness.

(*Continued on Page* 182)





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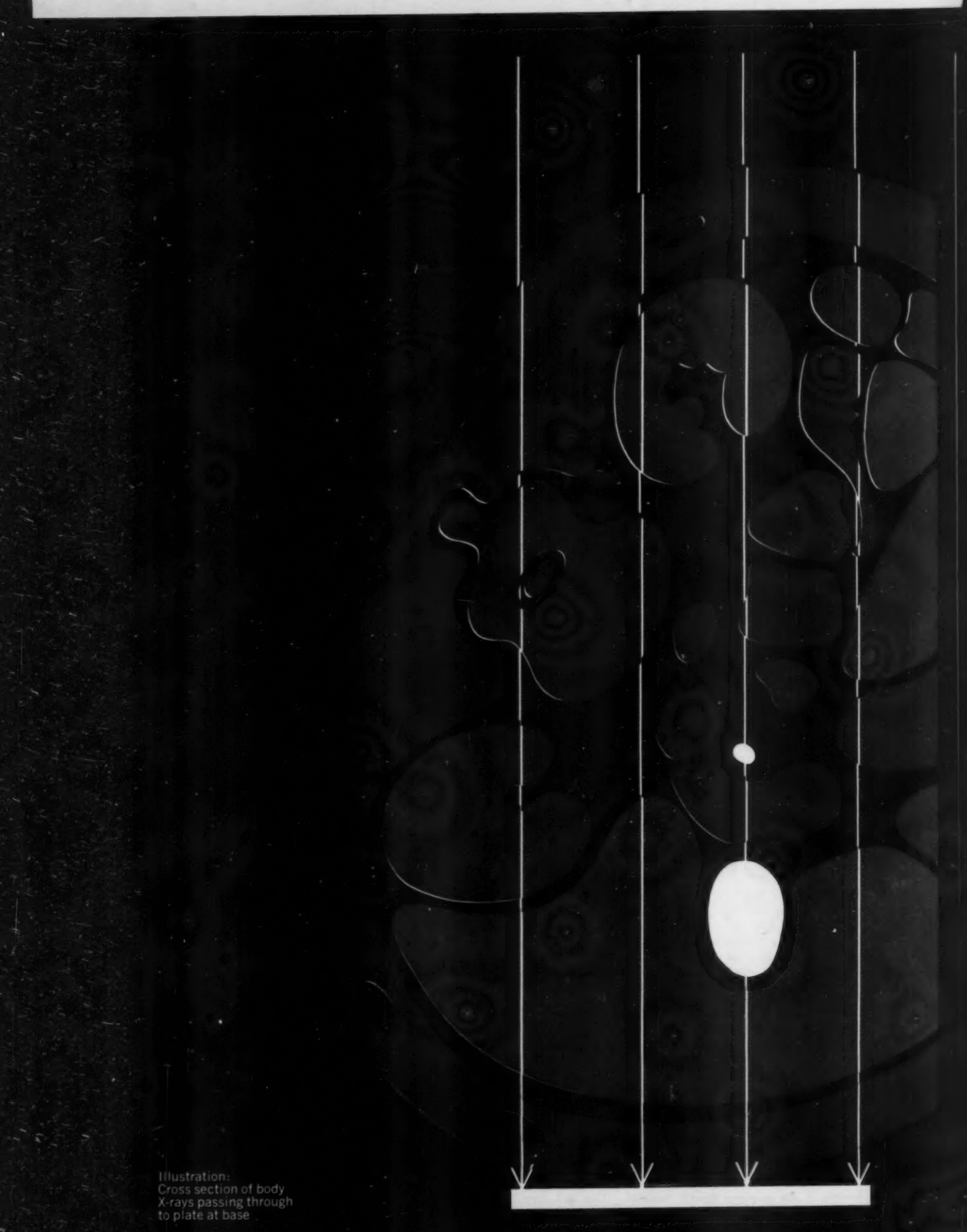


Illustration:
Cross section of body
X-rays passing through
to plate at base

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gallbladder function (concentrating ability) better demonstrated than with intravenous agents

fluoroscopy for spot films facilitated diagnosis of unusual abnormalities more frequent

How Supplied: Tablets of 500 mg., envelopes of 6 tablets, boxes of 5 and 25 envelopes; also bottles of 500.

1. Whitehouse, W. M.: Iopanoic acid, Ann. New York Acad. Sc. 78:809, July 2, 1959. 2. Baker, H. L., Jr., and Hodgson, J. R.: Further studies on the accuracy of oral cholecystography, Radiology 74:239, Feb. 1960.

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(*Continued From Page* 179)

Section 3. When an employe incurs an injury or disability for which he is entitled to workmen's compensation, but for which there is no workmen's compensation payment for the first three (3) days of absence from work, he shall be granted three (3) days pay for such disability or injury. This time off will not be charged against accrued sick leave.

ARTICLE VIII

Group Health Insurance.

Section 1. In the event that an employe, as designated herein, shall have been in the continuous service of the Employer for a period of six (6) months from the date of his or her employment, then, and in such event, during such period thereafter that the employe shall remain in the Employer's employment, Employer shall furnish Blue Cross and Blue Shield benefits in accordance with the "Comprehensive Plan" of Blue Cross and Blue Shield for the employe.

Group Life Insurance.

Section 2. Upon receipt of written, revocable authorization by the employe, the Employer agrees to deduct from the employe's wages bi-weekly an amount as certified by the Union, for group life insurance, such monies to be remitted to the Health and Welfare Department Council #48, AFSCME, AFL-CIO.

ARTICLE IX

Leave of Absence.

Section 1. Request for leave of absence may be granted by the Employer without forfeiting the employe's position provided that no rights shall accrue during such leave except as provided in this Agreement. Requests for leaves of absence shall be made in writing to the Employer.

Anything hereinabove to the contrary notwithstanding an automatic three (3) day leave shall be granted to an employe in event of the death of any member of his immediate family (parent, spouse, child, sister or brother).

Section 2. The Employer agrees to inform the Union of all employes granted leaves of absence. Any dispute arising out of the application of this Article will be subject to the grievance procedure of this Agreement.

Section 3. An employe on leave may return to work prior to the expiration of his leave provided not less than three (3) days' notice is given to the Employer. The return is at the option of the Employer. Any employe who fails to return to work in accordance with the notice given shall be considered as having voluntarily quit unless he gives a satisfactory reason.

Section 4. Leave time is excluded for vacation and other benefits. Employes who have been granted a leave for illness or for maternity must present a statement from their doctor, and check with the outpatient clinic before they return to work. Whenever an employe shall become pregnant she shall furnish the Employer with a certificate from her physician stating the approximate date of delivery, the nature of work she may do, and the length of time she may continue to work. Thereafter, upon request of the Employer, she shall furnish an additional certificate containing like information every thirty (30) to forty-five (45) days. It is recommended that an employe take a maternity leave of absence after the fifth month of pregnancy. In the event an employe desires to work after the fifth month, the permission of her physician and of the Employer must be secured. In no event shall an employe be allowed to work after the seventh month of pregnancy.

ARTICLE X

Seniority.

Section 1. Seniority is the relative status of employes based upon the following factors: (1) length of service, (2) knowledge and skill, and (3) physical fitness. Length of service shall govern when employes have substantially equal knowledge, skill and physical fitness.

Section 2. An employe who has been



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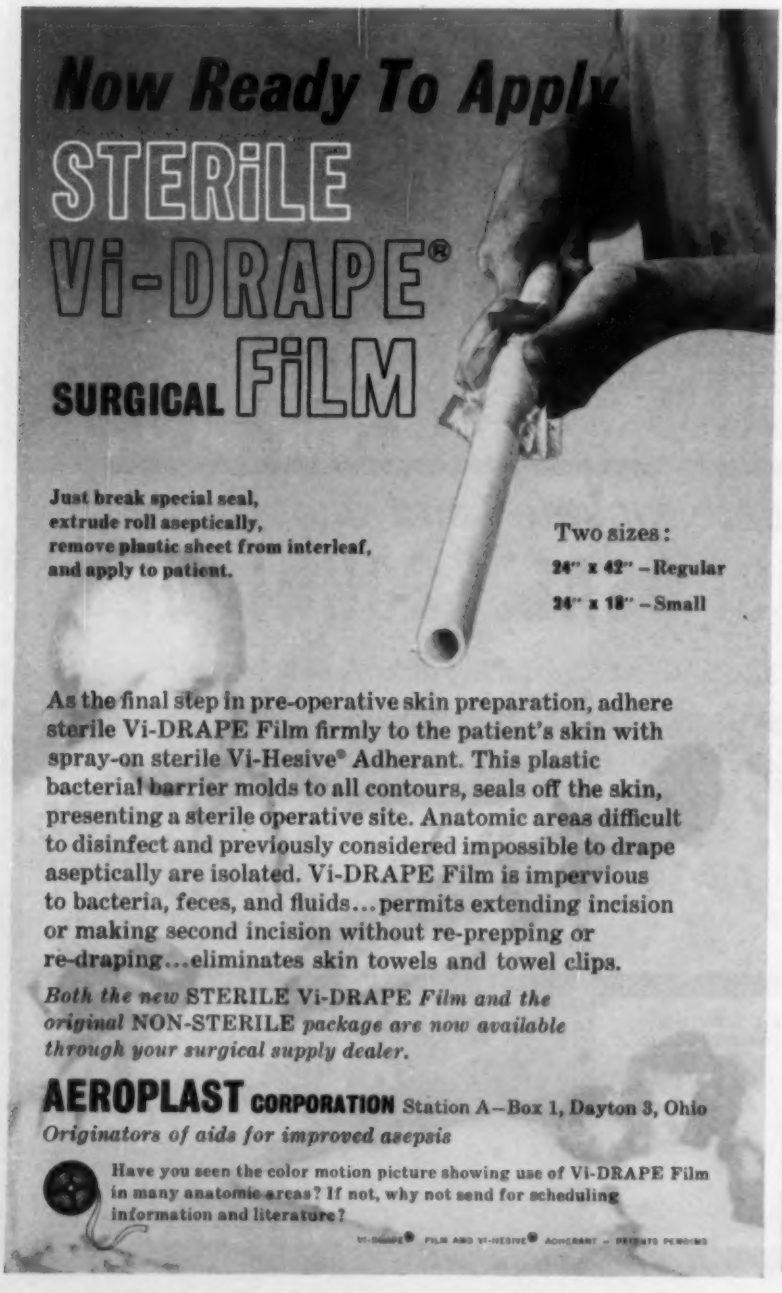
CITY_____ STATE_____

in the employ of the Employer for thirty-one (31) consecutive days shall be considered a regular employe of the Hospital unless an extension has been granted as referred to in Article II, Section 3, and will be granted seniority ranking from the date of hire. Until given seniority ranking an employe shall be subject to layoff, discipline or discharge at the sole discretion of the Employer.

Section 3. An employe rehired by the Employer will, after three (3) consecutive years of such reemployment, be entitled to have his last previous seniority rights applied to his present reemployment.

Section 4. In the event of layoff due to job elimination or lack of sufficient work, seniority rule must be adhered to. The Employer when rehiring will follow the reverse of the seniority procedure that was followed during the layoff and said employe's seniority will again become effective. In the event of a vacancy or work increase in one department, a laid off employe from another department will be given an opportunity to accept the position, provided the Employer determines in its sole discretion that the said employe has the necessary qualifications to fill the said position.

Section 5. Any employe whose employment is terminated by the Employer after one year of continuous service, except in case of discharge for cause, shall be given two weeks' notice or one week's pay in lieu of such notice.



ARTICLE XI

Grievance Procedure.

Section 1. (a) If any employe believes that he has any claim or complaint relating to wages, hours and working conditions, he shall first discuss the claim or complaint with his supervisor, or department head as designated by the Employer. In this discussion, he may be accompained by his steward. Should the claim or complaint not be satisfactorily adjusted within twenty-four (24) hours (week ends excluded), the claim or complaint shall be reduced by the employe to writing, and submitted in duplicate to the designated representative of the Employer, and the chief steward of the Union.

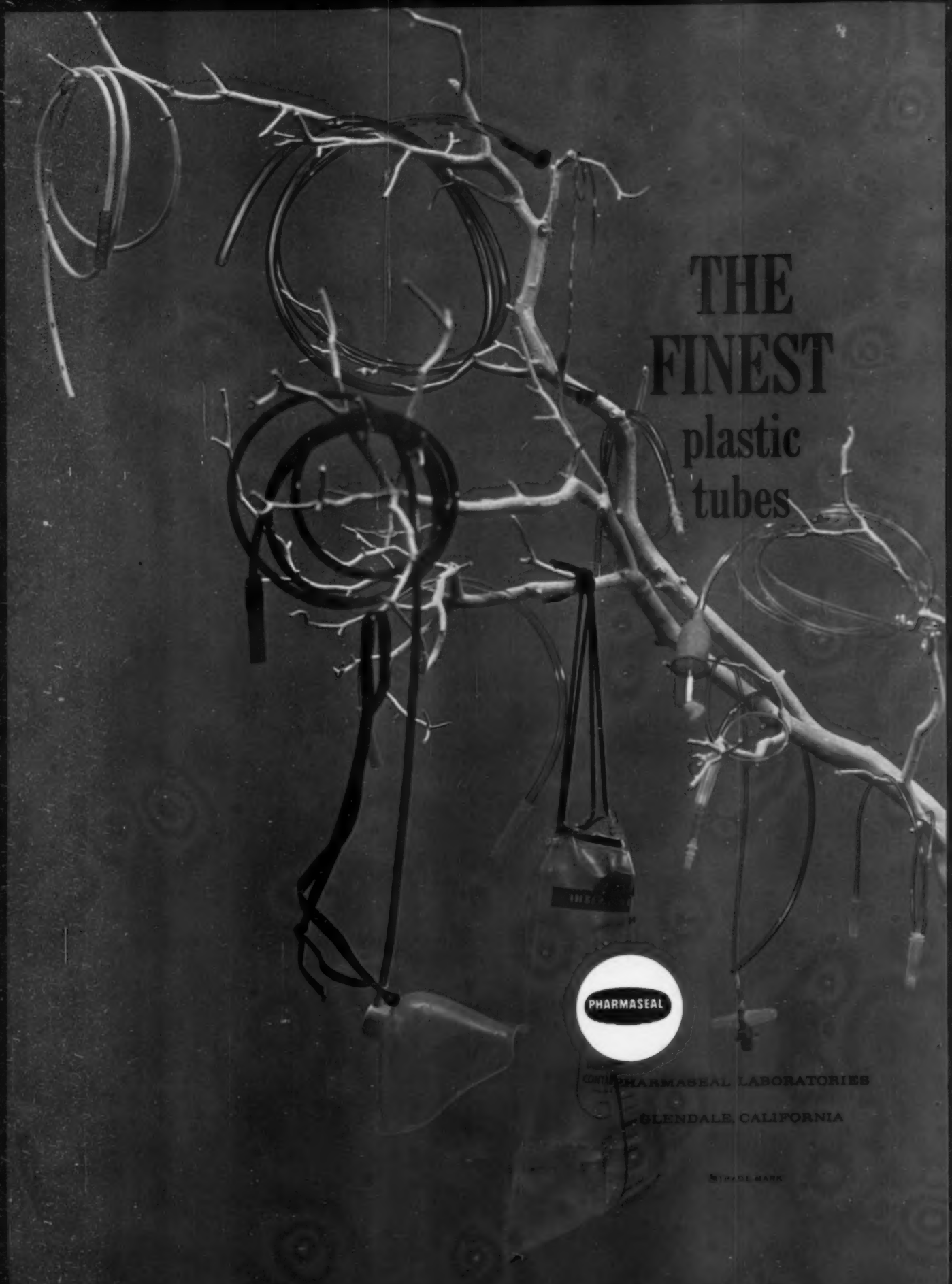
(b) Then the chief steward and/or his representative, the employe and the personnel director of the Employer, or a designated representative in his place, shall discuss the claim or complaint on a Tuesday or Friday of each week, whichever day occurs first. As much time as is necessary may be had to compose the matter. In all instances, the matter should be adjusted by or before the following meeting date of the representatives. The determination by the personnel director or designated Employer representative shall be in writing and submitted to the chief steward. In case of a claim or complaint of an emergency nature, the personnel director or designated representative of the Employer and the chief steward will adjust the matter as soon as possible.

(c) In the event there is no adjustment of the claim or complaint, the matter shall be discussed by the Union representative and the chief steward and the Employer's Administrator and designated Employer representative. Such representatives shall meet the Tuesday or Friday following the meeting, as set forth in paragraph numbered (b). In the event the matter cannot be adjusted with the Employer's Administrator within one (1) week following the original meeting of the representatives, it shall be referred for arbitration. Only matters involving the meaning or interpretation of the Agreement between the Employer and the Union shall be subject to arbitration.

(d) An arbitrator shall be mutually agreed upon by the Union representative and the Employer, and if such arbitrator cannot be mutually agreed upon, the Employer shall name one arbitrator, the Union shall name one arbitrator, and the two arbitrators so determined shall pick a third arbitrator.

(*Continued on Page* 187)


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(*Continued From Page* 184)

The decision of the arbitrator or arbitrators shall be final and binding on both parties; provided, however, that the arbitrator shall have no authority to add to, modify or change any provision of the Agreement.

Discharge and Discipline.

Section 2. (a) An employe may be discharged or disciplined for just cause. In the event any employe shall be discharged or disciplined, he shall be given the immediate opportunity to consult with his steward. However, the Employer may make the discharge or discipline effective immediately, as it shall determine.

(b) The steps of the grievance procedure as set forth above shall be followed, except that meetings will be held sooner if possible.

(c) In the event the matter cannot be adjusted between a Union representative and the Employer's Administrator within one (1) week's period of time after their first meeting, the matter shall then be referred within two (2) weeks to arbitration, as previously outlined.

(d) In any case where a warning is issued, copies shall be given to both the employe and the Union.

ARTICLE XII

The management of the hospital and affairs of the hospital and the direction of the working forces, including the right to hire, suspend, or discharge or discipline for proper cause, or transfer, and the right to relieve employes from duty because of lack of work, or for other legitimate reasons, is vested exclusively in the Employer; provided, that this will not be used for purposes of discrimination against the Union or any member thereof. The application of this section shall not conflict with the terms of this Agreement and shall not be used to nullify any of the provisions thereof.

It is agreed that an employe feeling himself aggrieved by any decision of the Employer in respect to matters covered by this Agreement, or the Union on his behalf, has the right to have such management decision reviewed under the grievance procedure herein set forth.

ARTICLE XIII

No Strike — No Lockout.

Neither the Union nor an employe shall authorize or participate in a strike or any concerted interference with the Employer's operations of any kind during the term of this Agreement. The Employer agrees that during the same period there shall be no lockout.

ARTICLE XIV

Hospital Rules.

The Hospital will post on the bulletin board specific notices involving changes

New BARNSTEAD Way to produce and store DISTILLED WATER

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The new Barnstead method of producing and storing distilled water offers four important advantages over present systems: First, it provides sufficient distilled water for *all* hospital services during peak need periods. Now you need not wait up to two hours each morning for an initial supply of freshly distilled water.

Second, Barnstead keeps distilled water chemically pure, pyrogen-free and sterile in storage. Distilled water can now be stored safely up to 30 days because Barnstead has developed the equipment for protecting distilled water purity.

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or modifications of hospital rules and regulations. Copies of any such change in rules and regulations shall be mailed to the Union office. These rules or regulations will go into effect forty-eight (48) hours after posting and mailing to the Union. In case of emergencies, however, these rules and regulations will go into effect immediately.

ARTICLE XV

Physical Examinations.

New employes will be given physical examinations at the time of employment and checkups at regular intervals as specific needs dictate. Any examinations required by law or by the Employer and given by the Employer are given free-of-charge. Conditions that require follow-up are referred to the employe's physician. A written statement from the employe's physician regarding the disposition of the referred conditions will be honored by the Employer.

Any employe off for illness may be required to be cleared by the employe health service in the outpatient clinic.

ARTICLE XVI

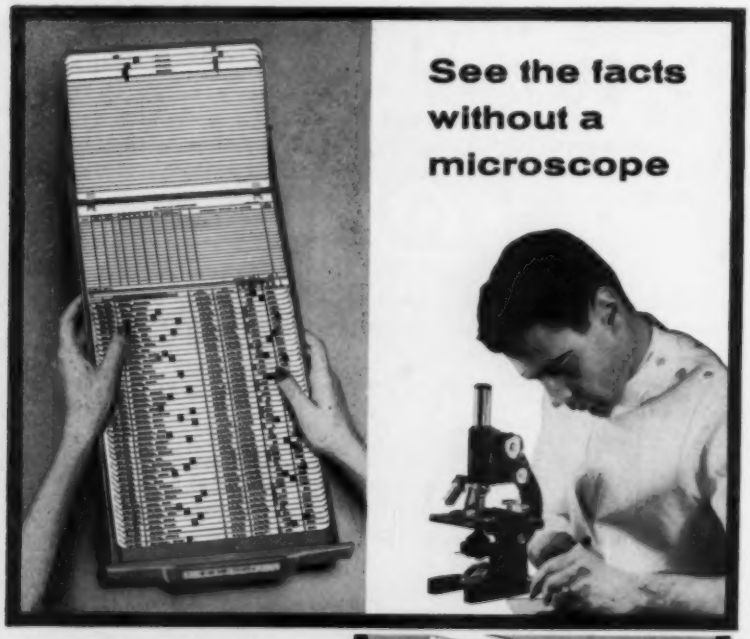
Bulletin Boards.

Bulletin board space suitable for Union notices shall be made available near each timeclock and at one location in the kitchen. Employes duly authorized as representatives of the Union may post in such space notices of Union meetings or elections, results of elections or appointment of officers, and notices of social, educational or recreational activities. Any other notices shall be posted only after approval by the Employer's personnel director.

ARTICLE XVII

Term of Agreement.

This Agreement shall be effective as of March 1, 1961, and shall continue in effect until October 31, 1962. This Agreement shall be automatically renewed for one (1) year on each anniversary date unless it is terminated or modified according to the procedure hereafter set forth. This Agreement may be terminated as of October 31, 1962, or any anniversary date thereafter by written notice by the Employer or the Union to the other delivered at least 60 days but not earlier than 90 days prior to October 31, 1962, or any anniversary date thereafter, of its desire to modify any term or terms of this Agreement. Such notice of modification shall specify which term or terms it desires to modify and shall set forth its proposals for modification. If either party gives notice of its desire to modify the Agreement, then the other party may have twenty (20) days after receipt of the notice of modification to give notice of its desire to modify any term or terms of the Agreement and shall specify what modifications are proposed. If Agreement on all proposals to modify has not been reached by October 31, 1962, or any anniversary date thereafter, then the Agreement shall terminate on that date unless the parties by mutual consent shall extend the Agreement.



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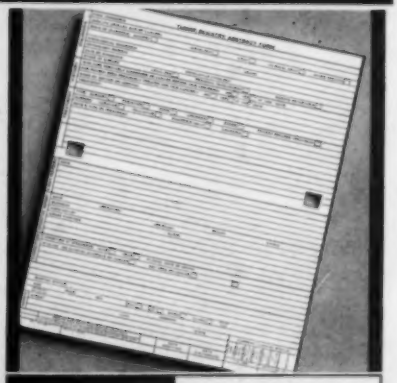
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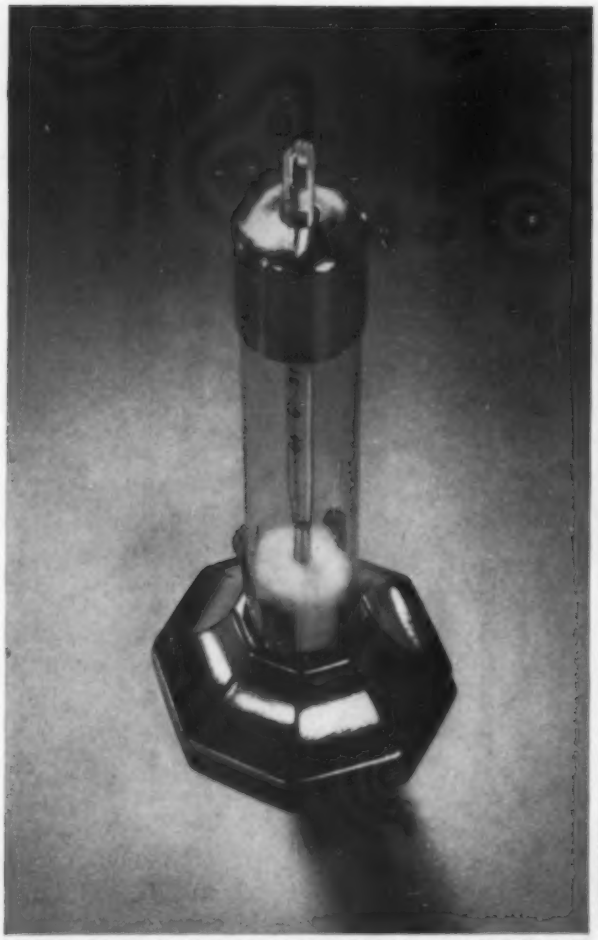
Name _____ Title _____
Hospital _____
City _____ Zone _____ State _____

Pennsylvania Groups Seek Medical Funds for Aged

HARRISBURG, PA. — Doctors and hospitals in Pennsylvania are urging the state legislature to take action to obtain federal funds for two assistance programs for the aged.

The Hospital Association of Pennsylvania and the Pennsylvania Medical Society joined forces to ask for legislation that will bring $3.6 million in federal funds to help pay for the medical care of persons already receiving old age assistance.

The two groups also asked the state to qualify for money for aged persons who are not normally on relief, but whose resources cannot be stretched to cover the costs of prolonged sickness.





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Armosol, the result of four years of exhaustive research, is a liquid synthetic cleaner and disinfectant that kills bacteria and deodorizes as it cleans. Armosol is particularly designed for hospital and institutional use where bacterial and fungal control are of prime concern.

Eight nationally advertised products of the Armosol type were thoroughly tested and compared with Armosol. The best *cleaner* of these fell far short of Armosol's efficiency. The best *germicide* was considerably less effective.

How it is used:

Armosol effectively cleans, sanitizes and deodorizes using the ordinary cleaning techniques, sponge, mop, floor machine, spray or flood. Armosol is also useful for cleaning refrigerators, stoves and other equipment as well as in the preliminary cleaning of surgical instruments.

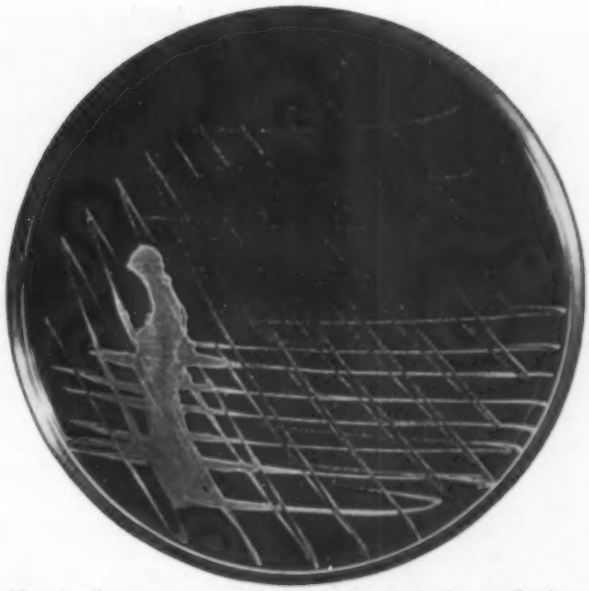
It is economical:

Armosol is odorless, readily soluble in both hard and soft water, non-staining, and is gentle to hands. It does three jobs at once—cleans, sanitizes and deodorizes. At the recommended concentration of 1½ ounces per one gallon of water, Armosol will clean and sanitize approximately 1500 square feet of surface. One gallon of Armosol makes 85.3 gallons of solution, or enough to clean about 127,950 square feet at an average cost per day of 1¼¢ per patient.

Environmental Sepsis Control:

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For technical information please write: B. J. Augst, Manager, Industrial Soap Division, Armour and Company, 1355 West 31st Street, Chicago 9, Illinois.



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Other tests: Using the Use-Dilution Confirmation Test (1953) which measures the kill at actual use levels, Armosol showed complete kill at 1:80 dilution against the test organisms, *S. choleraesuis* and *S. aureus*. The Chambers/Weber & Black Hard Water Tolerance Test (1958) was also used. Armosol destroyed 99.999% of these bacteria in water with a hardness of 500 ppm at the same dilution—and in just 30 seconds!

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Justice Department Sues Three Drug Companies for Antitrust Law Violations

WASHINGTON, D.C. — Three manufacturers of prescription drugs were indicted on antitrust charges here last month by the Justice Department.

Chas. Pfizer & Co., Inc., the American Cyanamid Company, and the Bristol-Myers Company were charged with maintaining unreasonably high and noncompetitive prices and monopolizing the production and distribution of antibiotic drugs since November 1953 in an action brought by the antitrust division of the Justice Department.

The companies denied any violation of antitrust laws had occurred and said the evidence would show they were not guilty as charged.

Two Others Named

In additional actions, the Olin Mathieson Chemical Corporation, parent company of E. R. Squibb & Sons, and the Upjohn Company were named as co-conspirators with the three other companies but were not charged with violation of antitrust laws.

The Justice Department said the alleged conspiracy had the effect of depriving patients, druggists, wholesalers, hospitals and government agencies of the "benefits of competition" in the distribution of broad spectrum antibiotics — tetracycline, aureomycin and terramycin.

The indictment said the five companies had introduced tetracycline at prices "substantially identical with each other and which conformed to the noncompetitive prices of terramycin products and aureomycin products in effect as of November 1953."

Charges Are Denied

"We emphatically deny that we have ever conspired to fix prices or have ever been a party to any action, conspiracy or agreement in violation of the antitrust laws," said a representative of one of the companies named.

"This action will be vigorously defended with confidence that our conduct will be completely vindicated," he said.



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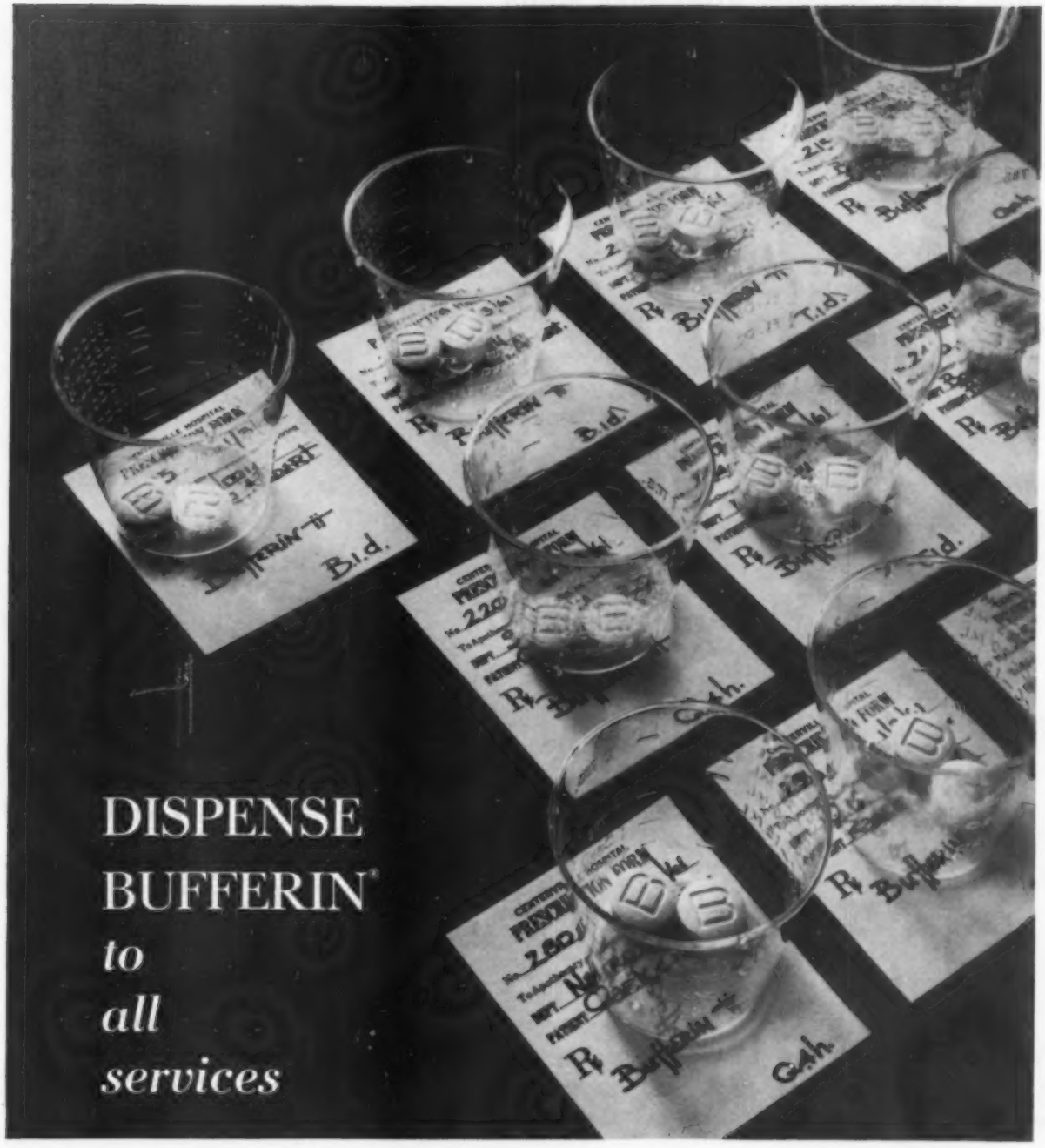
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Blue Cross, Hospital Association Battle Insurance Plan for Michigan Employes

DETROIT. — Who's scaring who seems to be the big question in a recent dispute over the state government's plan to enroll its 31,000 employes into a private group hospitalization program.

George N. Higgins, Michigan civil service commission chairman, has charged that Blue Cross-Blue Shield officials are using a "scare campaign" to block enrollment in the state sponsored plan.

In return, one Michigan Blue Cross official suggested that Mr. Higgins is afraid that he may not be able "to force his own program on the many state employes who want to stick with Blue Cross-Blue Shield."

William S. McNary, executive vice president of Michigan Blue Cross, also said that Mr. Higgins had failed to give employes complete information, did not consult with other state agencies and departments, and denied any expression of choice by employes themselves.

Mr. Higgins charged that the Michigan Hospital Association was being used as a "front" in questioning "the ethics of physicians, reports from state employes, agency officials, and hospital administrators themselves."

Specifically, he charged that "certain hospital administrators" have pushed the hospital association to take issue with the commission's statement that hospitals will honor identification cards given to state employes under the state program in the same manner as they receive Blue Cross-Blue Shield cards.

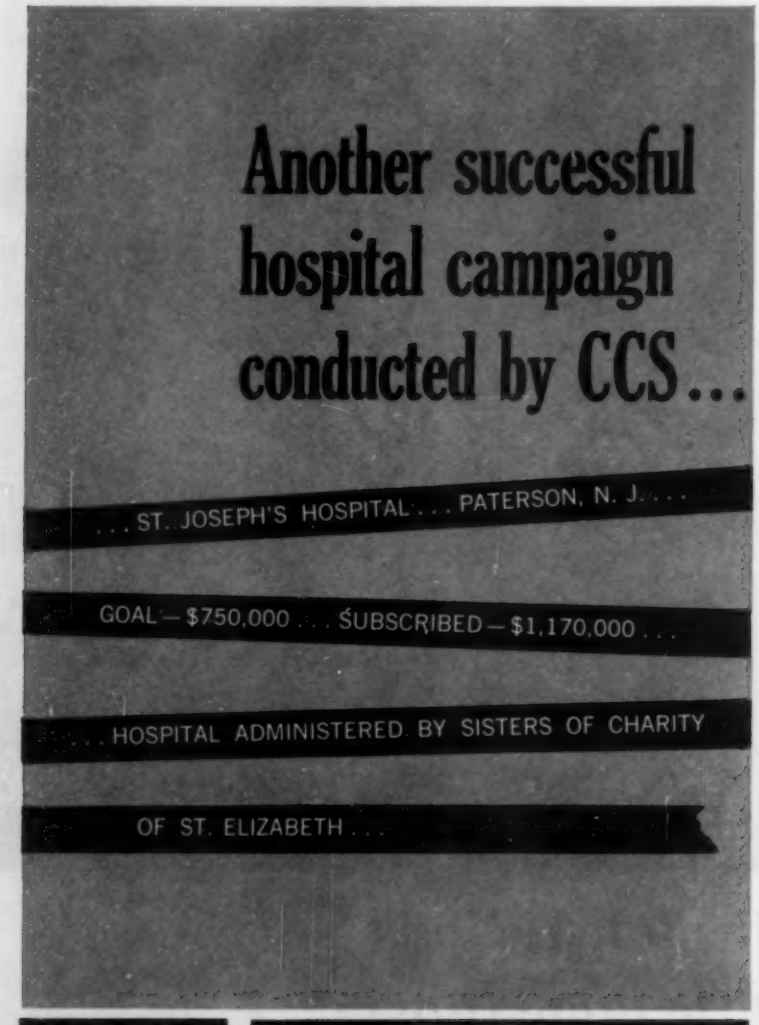
At its July meeting the executive committee of the M.H.A. had adopted a resolution stating, in part: "Resolved that the Michigan Hospital Association request the Michigan Civil Service Commission to advise employes in state service considering enrollment in its proposed health insurance plan that health insurance cards may not be honored without prior agreement with individual hospitals."

In its August newsletter the association explained that ". . . it became evident that the commission had no intention of imparting the contents of the resolution to its employes prior to the group insurance enrollment period. Michigan Hospital Service (Blue Cross), as an organizational member of the Michigan Hospital Association, received a copy of this resolution. It, in turn, duplicated the resolution and sent it to the state employes covered by its health insurance plan."

Bennett McCarthy, state director of hospitals for Blue Cross-Blue Shield, admitted Mr. Higgins' claim that the private insurance program would cost less but added "in the long run, its benefits are less — but that's a matter of opinion."

Mr. McCarthy pointed out that a "substantial block" of state employes in Michigan wanted to retain Blue Cross coverage.

He also said that under the state plan doctors have no obligation to hold payments for service within income limits prescribed by contracts. Under Blue Shield more than 80 per cent of the physicians are obligated to accept payments Blue Shield prescribes.



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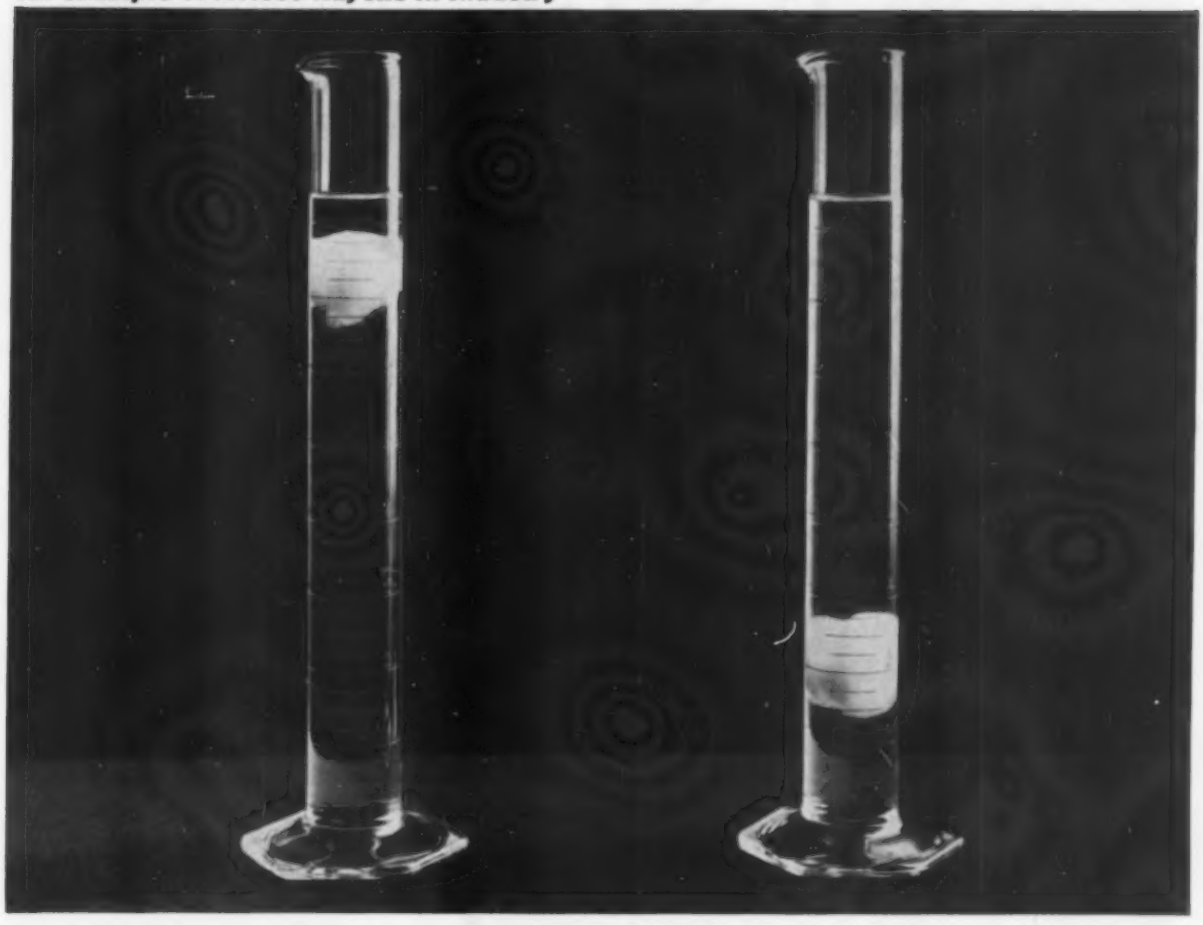
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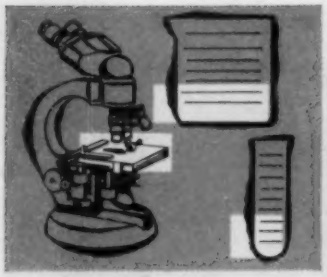
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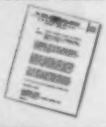


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Land Purchase Blocked After Hospital Denies Staff Rights to Doctor

TOLEDO. — The latest skirmish in an Ohio state senator's battle to have his family physician granted staff privileges has prevented the purchase of 40 acres of land from the state by St. Luke's Hospital here for the site of a new 200 bed hospital.

The hospital, along with all other Toledo hospitals, has refused staff privileges for Dr. Louis T. O'Desky, chiefly on the ground that he has not obtained an M.D. degree from an approved medical school.

The general practitioner's long-time friend, Frank W. King, state senator from Toledo, had reportedly tried to force St. Luke's to accept Dr. O'Desky by adding an amendment to the purchase authorization bill requiring the hospital to employ any licensed Lucas County physician. Although the bill passed the state senate, it was defeated by the lower house.

James G. Montgomery, administrator of St. Luke's, said the hospital is standing firm on its decision, and is investigating the possibility of purchasing privately owned land immediately adjacent to the selected site.

Dr. O'Desky's fight for hospital staff privileges covers more than five years. Although he has a degree in osteopathy, it is his medical degree from a now defunct Kansas City school of medicine that is at issue. Because the school is not approved in Ohio, he had been unable to obtain a license there until Senator King helped put through an amendment in 1955 permitting all veterans of the Korean conflict with M.D. degrees to take state board examinations — and even then there was a question. The Academy of Medicine in Toledo and Lucas County contend that Dr. O'Desky served the armed forces not as an M.D., but as an O.D.

Purchasing Agents Elect

MANCHESTER, CONN. — Robert Parisi of Norwalk Hospital, Norwalk, Conn., was elected president of the Hospital Purchasing Agents Association of Connecticut on June 7. Other officers elected were vice president, Paul Eule, U.S. Veterans Hospital, West Haven, and secretary-treasurer, Lois Dunham, Manchester Memorial Hospital, Manchester.



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Six Baltimore Hospitals Announce Plan To Establish Nonprofit Laundry Corporation

BALTIMORE. — Hospitals here have taken a third cooperative step designed to reduce operating costs by establishing a nonprofit laundry corporation.

Six hospitals have organized the venture to build and operate a plant capable of handling 12 million pounds of hospital laundry a year.

Previous joint efforts had been a group contract signed by 18 hospitals for the purchase of fuel oil, and one in which 28 hospitals joined to buy x-ray film.

Walter F. Perkins, president of the new organization, the Maryland Hospital Laundry, Inc., said provision has been made for doubling the laundry's capacity when other hospitals join the group or contract for laundry service.

The result of more than a year of study and planning by the Hospital Council of Maryland, the $1.6 million venture is expected to produce many advantages for the member hospitals. The council said it anticipates that shared service will: (1) reduce processing costs, (2) recapture space for patient care activities, (3) eliminate the need to replace antiquated machinery, and (4) permit the omission of laundries in hospital modernization and new construction.

A.M.A. Launches Drug Information Program

CHICAGO. — The American Medical Association, with the publication of its first special issue on therapeutics by the *A.M.A. Journal*, launched its expanded program of drug information.

The therapeutics issue contained summaries of more than 50 new drugs, plus six articles discussing new developments in various aspects of drug therapy.

This was the first of several publications planned by the A.M.A. to help keep physicians better informed on latest developments in new drugs (see The Modern Hospital, February *p.* 171).

"Our aim is to make unbiased information about the new drugs readily available to all practitioners in such a form that they can more readily use it," said Dr. Isaac Starr of Philadelphia, research professor of therapeutics at the University of Pennsylvania and chairman of the A.M.A.'s Council on Drugs.

French Hospital Meeting Honors Raymond Sloan

PARIS. — The seventh convention and exposition of hospital and health facilities in France was held here this spring under the sponsorship of the journal, "Techniques Hospitalieres."

Administrative, architectural and medical aspects of health care were included in the program as part of Public Health Week. The meeting attracted large numbers of doctors, surgeons, administrators, nurses and others in the health field.

During the meeting, Raymond P. Sloan, associate professor, School of Public Health and Administrative Medicine, Columbia University, and chairman of the editorial board of The Modern Hospital, was presented La Grande Medaille D'Argent De La Ville De Paris.

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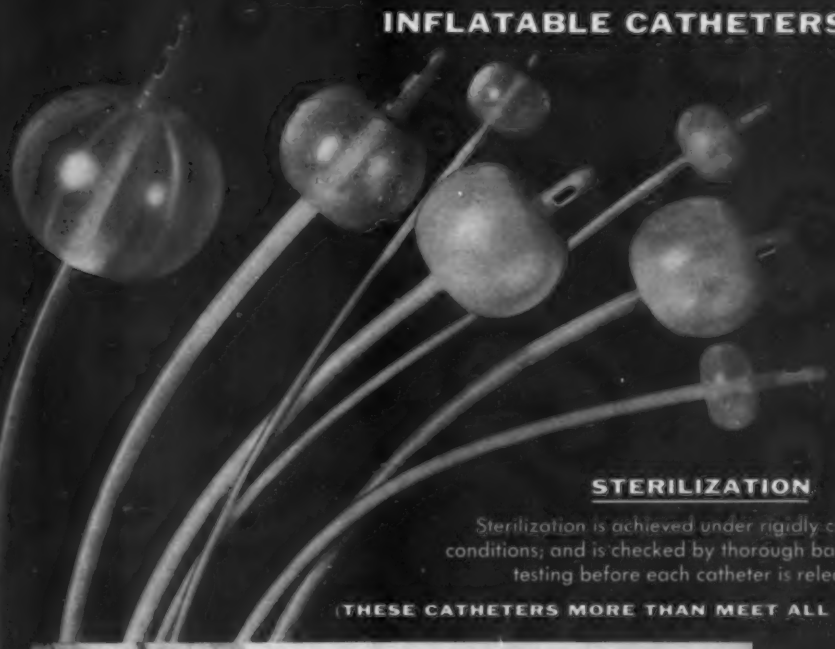
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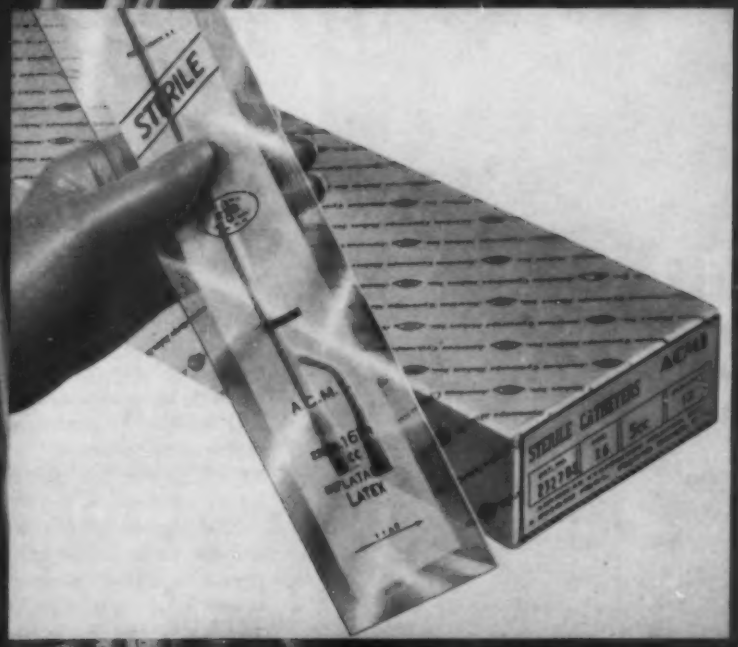


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Most Nurses Make Career Choice by Age 13; Study Suggests Early Recruitment

NEW YORK. — **The time to recruit future nurses is before they reach their teens.**

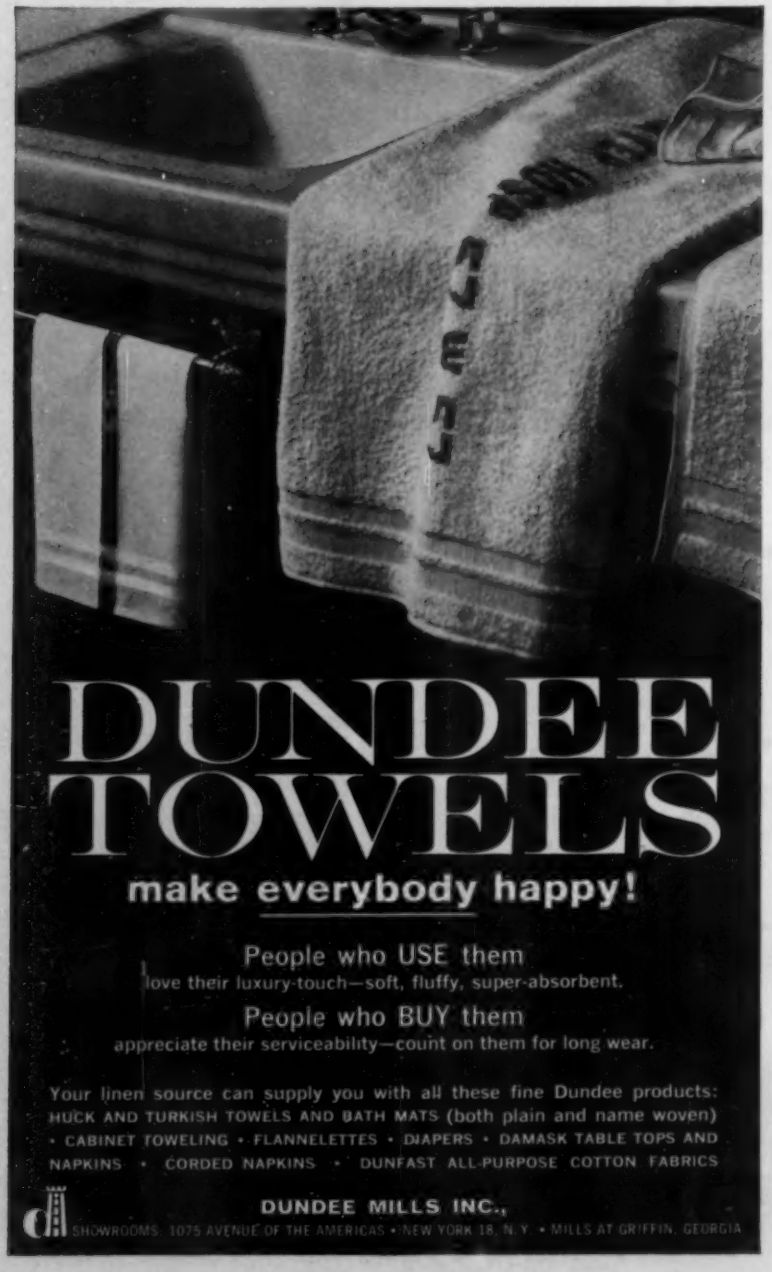
This was one conclusion that could be drawn from a recent survey conducted by the Institute of Research and Service in Nursing Education at Teachers College, Columbia University. It showed that more than 50 per cent of nursing students decided on nursing as a career by the time they were 13, and a good many of them were determined to be nurses by age 10.

The study, covering 4000 students in a random sample of 29 schools of nursing and 1500 nonnursing students in women's colleges, also showed that only 25 per cent of the nonnursing students had selected a career by age 15.

The fact that nursing students decided on their careers at an earlier age suggests that recruitment efforts in nursing might profitably be extended down to the junior high school level, the report noted. "This finding highlights the appeal of nursing to girls in their preadolescent and early adolescent years. The data also reflect the strength of that appeal: The desire to become a nurse is maintained through the junior and senior high school years," the report stated.

The survey also showed a difference in attitudes between nursing students in hospital programs and those in college degree programs. While the majority of nursing students would again major in nursing if they had the opportunity, the ones working in degree programs, just like nonnursing students, more often wish they had majored in something else as they progress deeper into their fields, the study disclosed.

In schools granting a diploma to their graduates, about one student in six expressed serious doubts about nursing in each school year, and the same number indicated they would study something different if they had the chance, the report noted.



V.A. Tests of Surgical Monitor System Brings Space Age Down to Earth

WASHINGTON, D.C. — **Electronic systems will monitor changes in patients' conditions during surgery and recovery in a research project under way at five Veterans Administration hospitals.**

The monitoring systems are basically adaptations of the instruments that have already proved practical to check on animal passengers in space rockets, it was reported. They record heart and brain activities, pulse, respiration, temperature, blood pressure, and other body conditions on an instrument similar to a television screen. The instrument can be seen by all members of the surgical team.

"Electronic monitors will be valuable for the increasingly complex surgery, including neurosurgery and open heart operations," noted Dr. Lyndon E. Lee Jr., head of research in surgery for the V.A., and they can "aid considerably in making the more complex surgical procedures safer for patients."

The systems have been established in Pittsburgh, Boston, Chicago, Durham, N.C., and Coral Gables, Fla.

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A nurse can actually serve more patients with the Motorola/Dahlberg system. And it's personalized service. The system shows the nurse the room and bed of the patient needing service. By simply lifting the handset, the nurse is in immediate 2-way contact with that patient.

A priority facility in the system allows a patient to be given "priority" attention when required—his calls are automatically channeled to the nurse ahead of others not requiring priority attention.

While it provides the most advanced features of modern communications, the new Motorola/Dahlberg system is within the budget limitations of virtually any hospital regardless of size.

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COMING EVENTS

AMERICAN ASSOCIATION OF BLOOD BANKS, Drake Hotel, Chicago, Oct. 25-28.

AMERICAN ASSOCIATION OF HOSPITAL CONSULTANTS, Shelburne Hotel, Atlantic City, Sept. 23.

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Benjamin Franklin Hotel, Philadelphia, Oct. 9-12.

AMERICAN ASSOCIATION OF NURSE ANESTHETISTS, Convention Hall, Atlantic City, Sept. 25-28.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Convocation, Convention Hall, Atlantic City, Sept. 24.

AMERICAN COLLEGE OF SURGEONS, Conrad Hilton Hotel, Chicago, Oct. 2-6.

AMERICAN DENTAL ASSOCIATION, Sheraton Hotel and Convention Hall, Philadelphia, Oct. 16-19.

AMERICAN DIETETIC ASSOCIATION, Sheraton-Jefferson Hotel and Kiel Auditorium, St. Louis, Oct. 24-27.

AMERICAN HOSPITAL ASSOCIATION, Annual Convention, Convention Hall, Atlantic City, Sept. 25-28.

AMERICAN NURSING HOME ASSOCIATION, Pick-Carter Hotel, Cleveland, Oct. 2-6.

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, Sheraton-Cadillac Hotel, Detroit, Nov. 6-8.

AMERICAN PUBLIC HEALTH ASSOCIATION, Cobo Hall, Detroit, Nov. 13-17.

AMERICAN SOCIETY OF ANESTHESIOLOGISTS, INC., Statler-Hilton Hotel, Los Angeles, Oct. 22-27.

AMERICAN SOCIETY OF CLINICAL PATHOLOGISTS, Olympic Hotel, Seattle, Sept. 29-Oct. 8.

ARIZONA HOSPITAL ASSOCIATION, Ramada Inn, Phoenix, Oct. 19, 20.

ASSOCIATED HOSPITALS OF ALBERTA, Hotel Palliser, Calgary, Oct. 10-12.

ASSOCIATION OF DELAWARE HOSPITALS, Dover, Oct. 12.

BRITISH COLUMBIA HOSPITAL ASSOCIATION, Hotel Vancouver, Vancouver, Oct. 17-19.

CALIFORNIA HOSPITAL ASSOCIATION, San Diego, Oct. 23-27.

COLLEGE OF AMERICAN PATHOLOGISTS, Seattle, Oct. 1-7.

COLORADO HOSPITAL ASSOCIATION, Boulder, Oct. 22-25.

FLORIDA HOSPITAL ASSOCIATION, Robert Meyer Hotel, Jacksonville, Nov. 16, 17.

HOSPITAL ASSOCIATION OF PENNSYLVANIA, Penn Harris Hotel, Harrisburg, Oct. 17, 18.

HOSPITAL ASSOCIATION OF RHODE ISLAND, Sheraton-Biltmore Hotel, Providence, Oct. 10.

IDAHO HOSPITAL ASSOCIATION, Elks Lodge, Boise, Oct. 16, 17.

ILLINOIS HOSPITAL ASSOCIATION, St. Nicholas Hotel, Springfield, Nov. 30, Dec. 1.

INDIANA HOSPITAL ASSOCIATION, French Lick Hotel, French Lick, Nov. 1-3.

KANSAS HOSPITAL ASSOCIATION, Baker Hotel, Hutchinson, Nov. 9, 10.

MARYLAND-D.C. HOSPITAL ASSOCIATION, Shoreham Hotel, Washington, Nov. 8-10.

MINNESOTA HOSPITAL ASSOCIATION, Leamington Hotel, Minneapolis, Nov. 9, 10.

MISSOURI HOSPITAL ASSOCIATION, Sheraton-Jefferson Hotel, St. Louis, Oct. 11-13.

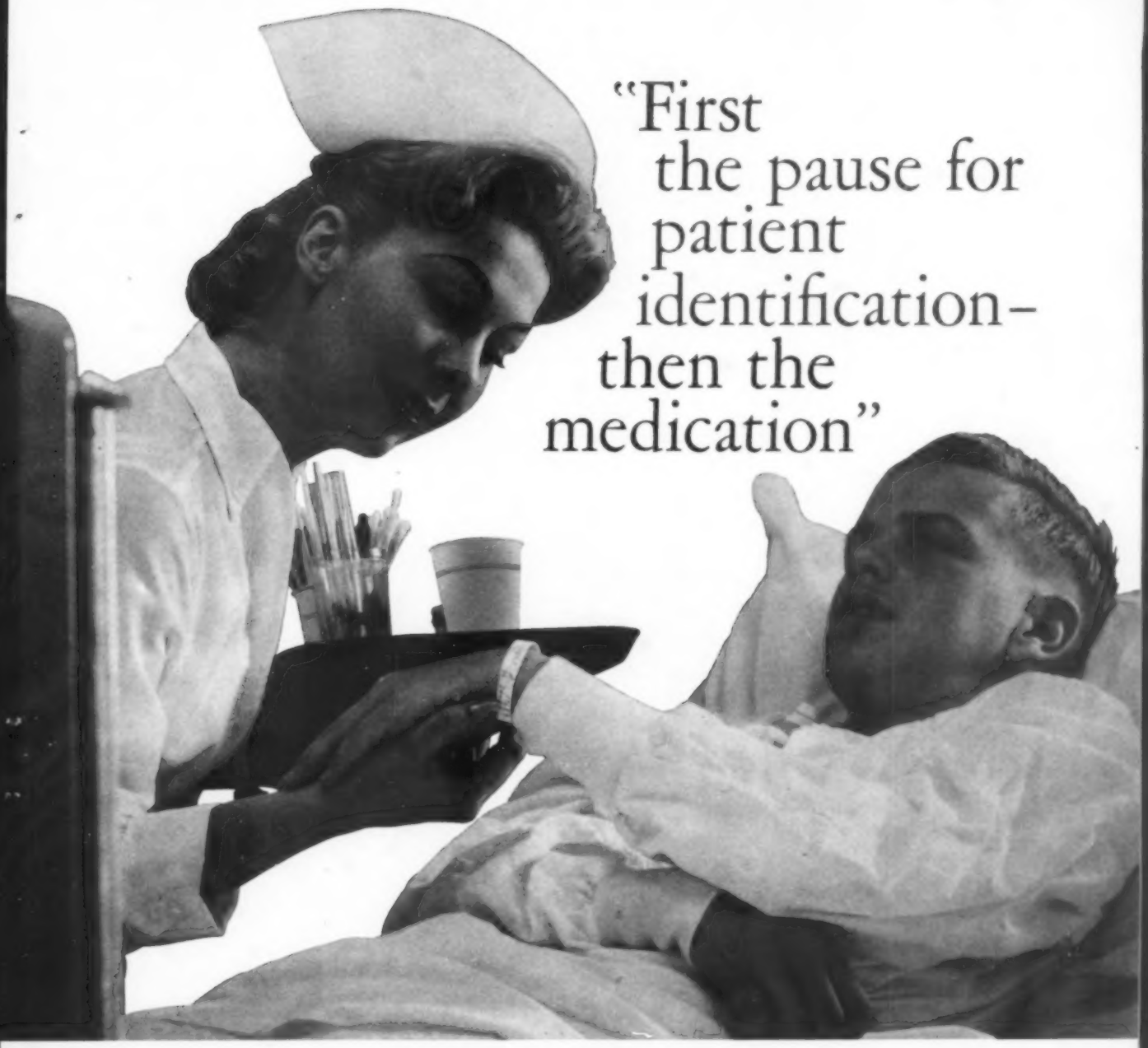
NATIONAL FEDERATION OF LICENSED PRACTICAL NURSES, INC., St. Paul Hotel, St. Paul, Oct. 2-6.

NEBRASKA HOSPITAL ASSOCIATION, Cornhusker Hotel, Lincoln, Oct. 12, 13.

NORTH DAKOTA HOSPITAL ASSOCIATION, Jamestown, Oct. 24, 25.

(Continued on Page 205)





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(*Continued From Page 202*)

OKLAHOMA HOSPITAL ASSOCIATION, Mayo Hotel, Tulsa, Nov. 2, 3.

ONTARIO HOSPITAL ASSOCIATION, Royal York Hotel, Toronto, Oct. 23-25.

OREGON ASSOCIATION OF HOSPITALS, Eugene Hotel, Eugene, Oct. 22-24.

RADIOLOGICAL SOCIETY OF NORTH AMERICA, Palmer House, Chicago, Nov. 26-Dec. 1.

SASKATCHEWAN HOSPITAL ASSOCIATION, Hotel Saskatchewan, Regina, Oct. 5, 6.

SOUTH DAKOTA ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Sioux Falls, Oct. 17.

SOUTH DAKOTA HOSPITAL ASSOCIATION, Sheraton-Cataract Hotel, Sioux Falls, Oct. 17, 18.

VERMONT HOSPITAL ASSOCIATION, Vermont Hotel, Burlington, Oct. 11, 12.

VIRGINIA HOSPITAL ASSOCIATION, John Marshall Hotel, Richmond, Nov. 9, 10.

WASHINGTON STATE HOSPITAL ASSOCIATION, Yakima, Oct. 26, 27.

WEST VIRGINIA HOSPITAL ASSOCIATION, Morgan Hotel, Morgantown, Oct. 19-21.

1962

AMERICAN HOSPITAL ASSOCIATION, Midyear Meeting, A.H.A. Headquarters, Chicago, Jan. 31, Feb. 1.; annual meeting, Chicago, Sept. 17-20.

MIDDLE ATLANTIC HOSPITAL ASSEMBLY, Convention Hall, Atlantic City, May 23-25.

MID-WEST HOSPITAL ASSOCIATION, Municipal Auditorium, Kansas City, Mo., April 25-27.

NEW JERSEY HOSPITAL ASSOCIATION, Convention Hall, Atlantic City, May 23.

California Architects Win Grand Prize Competition for Hospital System Plan

NEW YORK. – Grand prize in the Third Annual Architects' Competition was awarded to three California architects for their design of a coordinated suburban hospital system. Victor Cusack, A.I.A., Ronald Meza, and James Moore, A.I.A., were named as co-winners.

Mr. Cusack and Mr. Meza are affiliated with Charles J. Luckman Associates of Beverly Hills, Calif. Mr. Moore, who was affiliated with Luckman Associates at the time the award was presented, is now with Medical Planning Associates of Beverly Hills.

The competition was for the best design of a coordinated hospital system for a rapidly growing satellite city. Mastic tile division of the Ruberoid Co. was the sponsor.

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Large 5″ casters (standard equipment) make the bed easy to move, yet in low position the top of the spring is only 17″ from the floor.

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The entire spring and mattress assembly folds into one compact, upright position for quick, easy, more complete cleaning. There are no obstructions such as sharp edges or racks to impede cleaning. All exposed metal parts of foot end and inner legs are covered with stainless steel—no paint to chip off. The edges of all end panels are protected with extruded anodized aluminum trim.

The No. 68 Hill-Rom All-Electric Hilow Bed is listed by Underwriters' Laboratories, Inc., re-examination service, for use with oxygen administering equipment.

HILL-ROM COMPANY, INC. · BATESVILLE, INDIANA

For additional information, use postcard facing back cover.

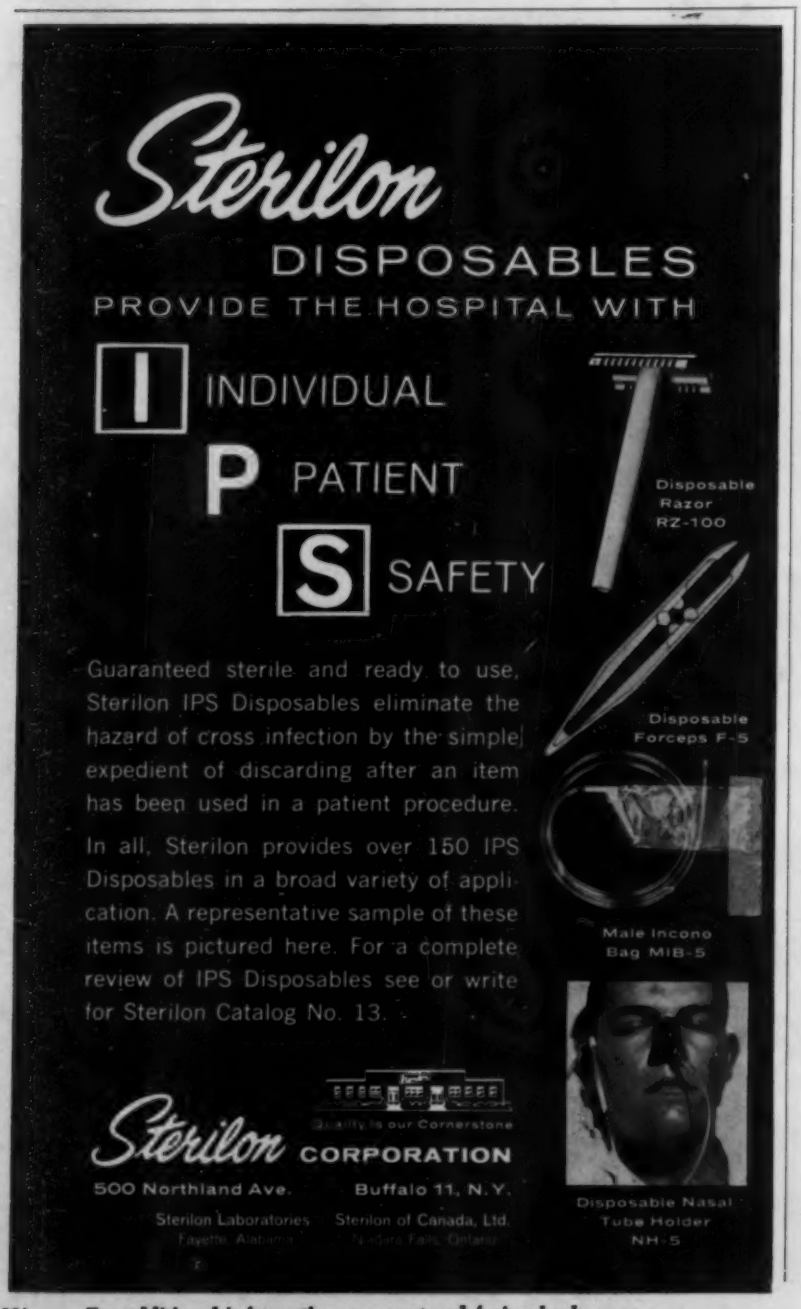
Kansas City Hospitals Plan $41 Million Renovation

KANSAS CITY, MO. — United Hospital Fund of the Kansas City Area has launched an $18 million drive for modernization and replacements programs of 17 private voluntary hospitals in the metropolitan area.

The hospitals themselves are adding $23 million for a total renovation cost of $41 million over the next five-year period.

The areawide hospital planning agency, in a study of general bed needs as well as condition of existing hospitals, recommended the 17 institutions as having the most serious problems of obsolescence. Four hospitals are scheduled for complete replacement and relocation.

No major addition of hospital beds is contemplated. In the planning process, more than 1400 programed general beds, some actually under construction, were eliminated. The planning agency believes present beds, after modernization, will be adequate until 1970.



Planning Group Frowns at Proposed K. C. Hospital

KANSAS CITY, MO. — Negro Baptist leaders here are going ahead with plans for a new Wheatley-Provident Hospital despite disapproval of the project by the Kansas City Area Hospital Association.

The association's planning committee recommended against including the project in the United Hospital Fund.

The committee cited low occupancy at the hospital, increased integration of Negro patients and doctors into many hospitals, and surveys showing that new hospital beds are not needed in the area for an estimated 10 years.

Defending the project, a commission of the Negro Baptist church leaders said: "We believe there is a definite place here for a Wheatley-Provident Hospital open to all races, but predominantly controlled by the Negro population and predominantly staffed by Negro doctors."

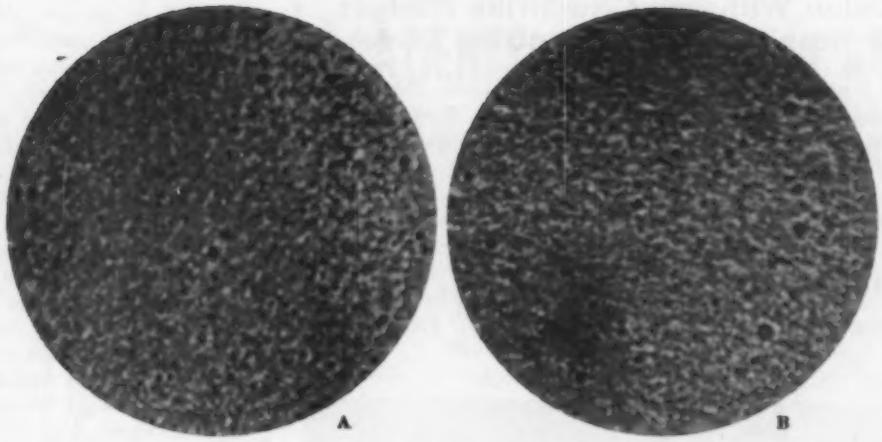
Plan Major Changes in V.A. Hospital Design To Meet New Trends

WASHINGTON, D.C. — Increased automation in medicine and the trend away from specialized hospitals and toward general hospitals will cause major changes in the Veterans Administration 12 year hospital modernization program.

Commenting on the $900 million project, Dr. William S. Middleton, V.A. chief medical director, said the large psychiatric hospital with its dormitories is a relic of the past and even the 1000 bed hospitals for the mentally ill projected at present appear unwieldy.

"The early passing of special hospitals can be foreseen," Dr. Middleton said, "and the future in the V.A. system will unquestionably witness the evolution of a hospital complex incorporating the several essential elements into a cohesive, well coordinated whole."

Although the V.A. has only begun to adapt itself to the technics of automation in medicine, Dr. Middleton sees the movement toward automation as inevitable and having major effects on hospital design and construction.



A B

Which is chyle and which is Lipomul I.V.?†

As you know, after digestion, fat passes as an emulsion called chyle through the lacteals into the lymphatics tributary to the thoracic duct, and then into the systemic circulation. Lipomul I. V., like chyle, is a fine milk-white emulsion of fat. Its fat particles approximate those of chyle in size: about *1/7 the diameter of the normal red blood cell.* Because of this minute particle size, like chyle, Lipomul I. V. is *non-irritating to the vein.* The fat provides *8 times more calories* per cc. than does 5% glucose and with markedly increased protein-sparing action. It is *swiftly* and *completely metabolized.* Therefore, when formation of chyle, a major source of calories, is blocked during pre- and post-operative "digestive tract bypass," many surgeons add Lipomul I. V. to their standard fluid and electrolyte regimen to provide the most concentrated source of energy.

†A—Mammalian chyle (highly magnified)
B—Lipomul I. V. (highly magnified)

Formula:

Cottonseed oil	15% w/v
Dextrose anhydrous	4% w/v
Lecithin	1.2% w/v
Oxyethylene oxypropylene polymer	0.3% w/v
Water for injection	q.s.

Supplied in 250 cc. and 500 cc. bottles

Indications and effects

Lipomul I. V., fat emulsion for parenteral use, supplies approximately 400 calories per 250 cc. It is indicated in patients who are unable to take adequate food by mouth for any considerable period of time.

Administration and dosage

Administer only by intravenous route, as follows:

For adults	
First 5 minutes	10 drops/minute
Next 25 minutes	40 drops/minute
Then	60 drops/minute
For infants and children	
First 5 minutes	5 to 10 drops‡/minute
Next 25 minutes	0.5 to 1 drop per pound/minute
Then	0.5 to 1 drop per pound/minute

‡*1 cc.—approximately 20 drops.*

Precautions and side effects

To administer, use only the recipient set supplied in the package; Lipomul I. V. must not be mixed with transfusions, infusions, or any other parenteral medication, or be given simultaneously through the same tubing. A total of not more than 14 units (500 cc. each), at a rate not exceeding 2 units per day, should be given to any one patient.

Reactions of a "colloid" type may occur, including back or chest pain, dyspnea, severe flushing, or urticaria. There may be delayed chill. Transient fever has also been noted, as have such other minor reactions as nausea, vomiting, abdominal discomfort, headache, mild flushing, dizziness, and some variations in blood pressure and pulse.

When the recommended dosage is exceeded, an "overloading syndrome" may occur characterized by chill, fever, abdominal pain, nausea, vomiting, hepatomegaly, clotting defects, thrombocytopenia, and bleeding, particularly from the gastrointestinal tract.

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New strike threat

New York Union Withdraws No-Strike Pledge; 39 Nonprofit Hospitals Face Organizing Drives

NEW YORK. — A no-strike pledge affecting 39 nonprofit hospitals here has been withdrawn by Local 1199, Drug and Hospital Employes Union.

Reason for the action, according to Leon J. Davis, president of the Local, was failure of the hospitals to sign a policy statement that, among other things, established a permanent committee for reviewing wages of nonprofessional employes. The statement was developed by the Greater New York Hospital Association in 1959 following settlement of a 46 day strike against seven local hospitals.

In a letter to Mayor Wagner, Mr. Davis said that the association had pledged that at least 80 per cent of its 81 members would sign the policy statement, the *New York Times* reported. In two years, he said, 39 hospitals have endorsed the statement and 39 have not. Ten other hospitals, three of them association members, have signed individual contracts with the union, he indicated.

"The members of our union," wrote Mr. Davis, "have therefore decided that the no-strike pledge given to you last year will apply only to those hospitals which have already signed the statement of policy and abide by the recommendations of the permanent administrative committee."

Mr. Davis, however, was also critical of the performance of the permanent administrative committee, which he said had failed "to act as a truly impartial agency."

Workers in hospitals where the no-strike pledge has been withdrawn will be organized with a view toward demanding full collective bargaining, Mr. Davis told the *Times*. If this is refused, he added, the union "will not hesitate to call a strike."

Mr. Davis predicted that he would have a majority of nonprofessional workers organized in some of the hospitals within a month.

In announcing the withdrawal of the no-strike pledge, he said, "there is no question that this is going to result in some strikes."

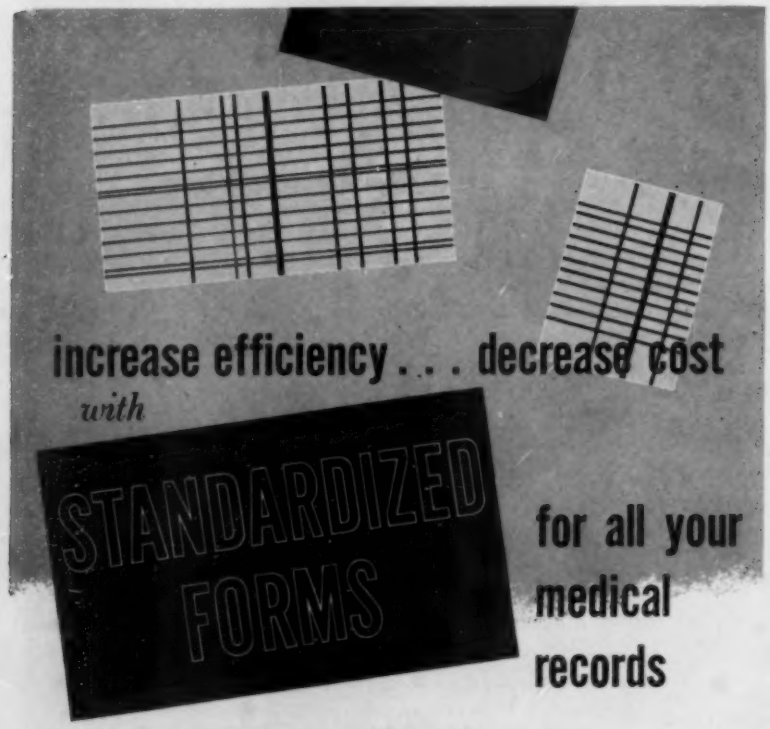
Building Service Local Signs Two New Contracts

NEW YORK. — Contracts covering more than 200 workers and providing wage increase and health-welfare coverage have been signed at two hospitals here with Building Service Employes Local 144.

The contracts, which have essentially the same provisions, were negotiated with Pelham Bay General Hospital, Bronx, and Interboro General Hospital, Brooklyn, according to *Services Labor Report*.

Provisions include a $1.10 hourly rate, a five cent raise effective in September, and another nickel starting March 1962 for maids, nurse's aides, porters and kitchen men.

The health-welfare program, estimated to cost the hospital $2 per week per employe, provides family Blue Cross coverage for employes with six or more months of service, as well as a $1000 life insurance policy.



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ABOUT PEOPLE

(*Continued From Page* 126)

C. Henry Hottum, assistant administrator of Methodist Hospital, Memphis, Tenn., has been awarded the Frederick C. Morgan individual achievement award by the American Association of Hospital Accountants. Mr. Hottum, a C.P.A., is a past president and fellow of the A.A.H.A., and organized the Tennessee chapter, of which he has also served as president and director.

Jerry E. Poole, assistant administrator of Blessing Hospital, Quincy, Ill., has been named administrator of Brokaw Hospital, Normal, Ill. Mr. Poole holds a master's degree in hospital administration from the State University of Iowa.

Arthur A. Lepinot is now director of Lakewood Hospital, Lakewood, Ohio. Formerly, he was administrator of Roswell Park Memorial Institute, Buffalo, N.Y.

John Paul Barrett has been appointed administrator of Syracuse Memorial Hospital, Syracuse, N.Y. Mr. Barrett was assistant administrator of Memorial Hospital of Chatham County, Savannah, Ga.

Sister Claudia has been appointed administrator of St. Ignatius Hospital, Colfax, Wash. She had been assistant administrator of St. Patrick Hospital, Missoula, Mont.

Brig. Gen. John L. Crawford has been named commander of Madigan General Army Hospital, Tacoma, Wash.

Patrick A. Duffy has been named to the newly created post of administrator of Taylor Hospital, Taylor, Pa. **Beatrice Carden,** who has been hospital superintendent, will become director of nurses.

Mitchell M. Waife has been named executive director of the Home for Aged and Infirm Hebrews of New York. He has been assistant director of the Home since 1949. At the same time it was announced that **Minna Adler Stern** was named associate executive director of the Home.

Sister Marcelle Odile has been named administrator of St. Peter Hospital, Olympia, Wash., succeeding **Sister Germaine.**

Sister Stella Marie has been named administrator of St. Joseph Hospital, Vancouver, Wash., succeeding **Sister Theodula.**

Luella H. Huffman has become the administrator of Guadalupe Valley Hospital, Seguin, Tex.

Richard A. Stolnacke, formerly assistant administrator, Lutheran Hospital, Baltimore, has been made administrator of that institution. Mr. Stolnacke is a graduate of the course in hospital administration at Columbia University.

Billy R. Talbert has resigned as administrator of Clinton General Hospital, Clinton, Mo., to become assistant administrator at Blessing Hospital, Quincy, Ill.

Lewis Lesser has been named administrative assistant at Beekman-Downtown Hospital, New York. Mr. Lesser has a master's degree in hospital administration from Columbia University.

Robert W. Bradley has been named assistant administrator-controller of Harrison Memorial Hospital, Bremerton, Wash. Previously, he was business manager of the University Hospital, University of Washington.

Sister M. Patricia is the new administrator of St. John's Hospital, Longview, Wash. (*Cont. on p.* 212)

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cuts your costs
speeds your service

"Too many cooks can spoil the broth"... and your cost control picture as well.

With Dri-Heat centralized feeding you no longer need "too many cooks." Instead you keep costs down to a minimum by eliminating duplicate efforts in several kitchens—and you end food waste. Best of all, you can increase menu variety and improve the "patient appeal" of all the food you serve.

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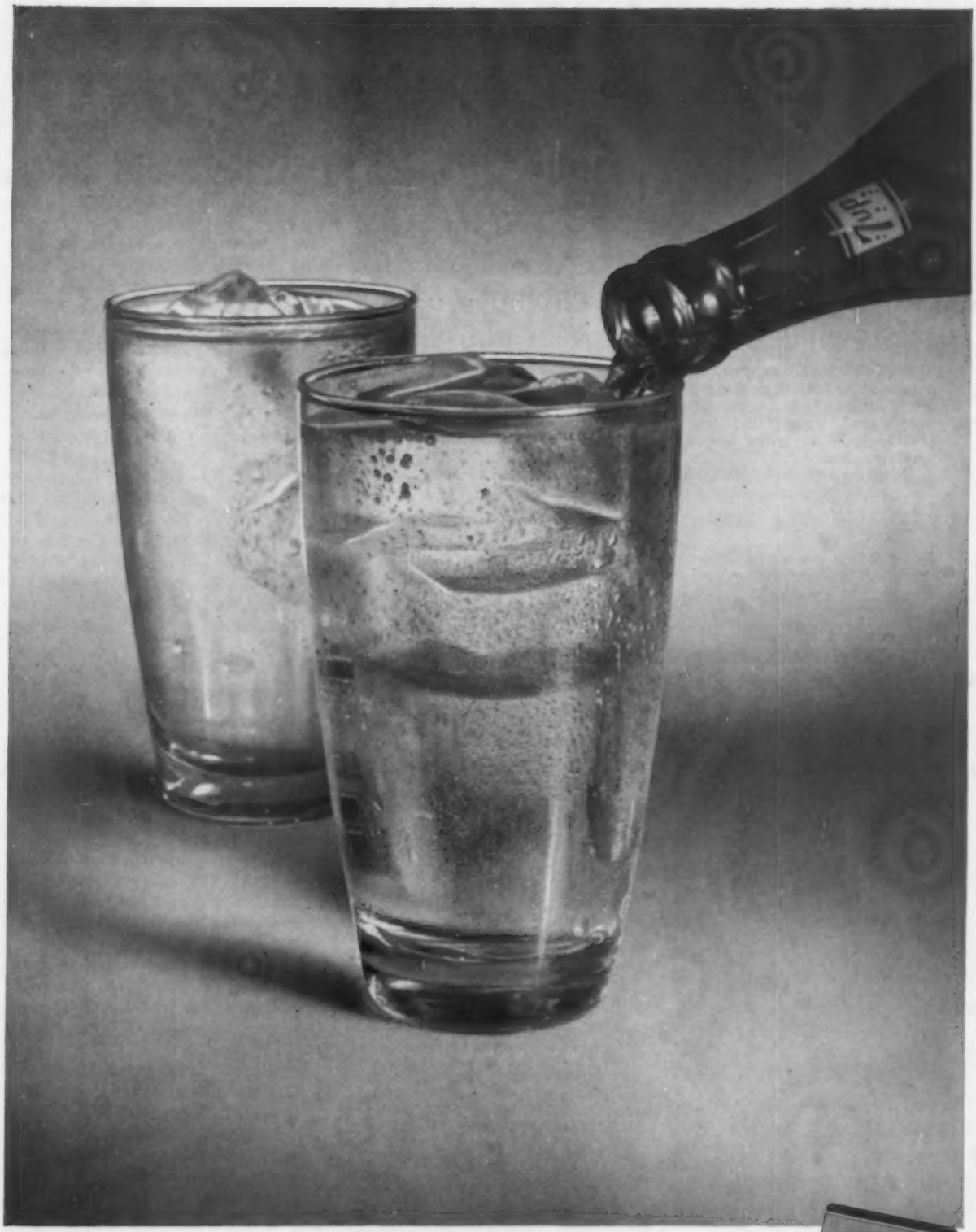
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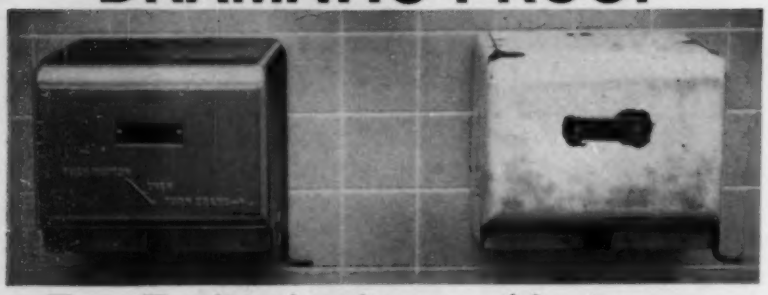
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(*Continued From Page 210*)

Charles Farnsworth has been appointed assistant administrator of Wuesthoff Memorial Hospital, Rockledge, Fla.

Thomas J. Markson has been appointed assistant administrator of St. Luke's Hospital, St. Paul. He is a graduate of the University of Minnesota's course in hospital administration.

John Q. Wimmer is the new administrative assistant and night administrator, University Hospital and Hillman Clinic, Birmingham, Ala. At the same time the hospital announced that **Bona Parnell Langston** has been appointed administrative assistant for personnel and information.

Steven Sieverts has been named assistant administrator of Hunterdon Medical Center, Flemington, N.J. Mr. Sieverts is a graduate of the Columbia University program in hospital administration.

William D. Hilliard has become administrative assistant at Euclid-Glenville Hospital, Euclid, Ohio.

Hugh R. Owens is the new assistant administrator of Tacoma General Hospital, Tacoma, Wash. He has been an administrative assistant there since 1958. Mr. Owens holds a master's degree in hospital administration from Northwestern University.

Ted Druhot is now assistant administrator at St. Joseph's Hospital, Fort Wayne, Ind.

Carney W. Wright, formerly assistant administrator of the University of Tennessee Hospital, Knoxville, has accepted the administratorship of Memorial Hospital, Clarksville, Tenn. **James Hampton** has succeeded Mr. Wright at the University hospital.

Eugene K. Prentice, former assistant administrator of Good Samaritan Hospital, Lexington, Ky., is assistant administrator of Mound Park Hospital, St. Petersburg, Fla.

Donald H. Dinger is the new assistant administrator of Muskogee General Hospital, Muskogee, Okla.

Milton Holmgrain is the new administrative assistant at Proctor Community Hospital, Peoria, Ill.

Melvin J. Simak has been appointed administrative assistant at Lebanon Hospital, Bronx, N.Y. He was formerly research associate in public health at the New York Academy of Medicine. Mr. Simak is a graduate of the University of Pittsburgh's program in hospital administration. (*Continued on Page 214*)

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LINDE COMPANY UNION CARBIDE

(*Continued From Page* 212)

Peter Johnson has been promoted from night administrator to assistant director of Michael Reese Hospital, Chicago. **Frank J. Occhiuto** succeeds him as night administrator.

James S. Urda has been named administrative assistant, Episcopal Hospital, Philadelphia. He received his master's degree in hospital administration from the University of Michigan.

Raymond W. Leitner has been appointed assistant administrator and **Richard T. Macias Jr.** purchasing agent at John C. Lincoln Hospital, Phoenix, Ariz.

Robert Stevenson has been named associate administrator of the Medical Arts Hospital, Houston, Tex.

Charles A. Bowen has become assistant administrator of Park City Hospital, Bridgeport, Conn.

A. Riley Allen has been appointed assistant administrator and **David M. Hunter** administrative assistant at Crittenton General Hospital, Detroit.

Phillip Holmes has been named business manager at the University of Oklahoma Medical Center.

James C. Kenney has been appointed controller at Munroe Memorial Hospital, Ocala, Fla.

Carl S. Jackson has become business manager of All Saints Episcopal Hospital, Fort Worth, Tex. Prior to this appointment he was administrator of Reagan Memorial Hospital, Big Lake, Tex., and assistant administrator of Clinic Hospital, San Angelo, Tex.

Department Heads

Oma Hill has been appointed assistant director of nursing service of Medical Center Hospital, Tyler, Tex.

Forrest Wright is the new personnel director for Research Hospital, Kansas City, Mo., succeeding **James A. Faires,** who is now assistant administrator at Missouri Methodist Hospital, St. Joseph.

Joan Riley was appointed director of nursing service at the Salem General Hospital, Salem, Ore. She was formerly associated with the J. Hillis Miller Health Center, Gainesville, Fla.

Sister M. Antonita has been named director of nursing services at St. Francis Hospital, Escanaba, Mich. Other appointments at St. Francis are **Sister M. Joselinda** to head the surgical department, central supply, and recovery room, and **Sister M. Vianney** to supervise and be chief technician of clinical laboratories.

Edna Mae McIlveen has been named director of nursing at St. Luke's and Children's Medical Center, Philadelphia.

Dr. Maurice Levine will retire from his position as medical director of Michael Reese Hospital and Medical Center, Chicago, at the end of 1961.

June Russo is the new director of nursing service at St. Francis Hospital, Evanston, Ill.

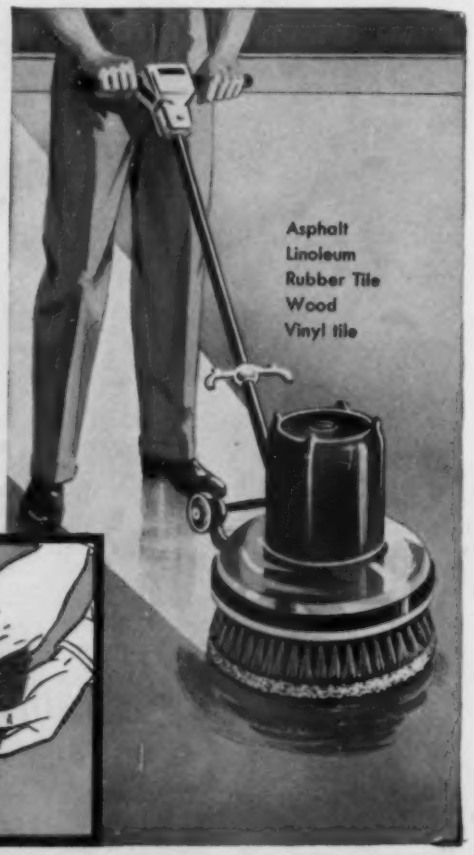
Emma Bowen has accepted the position of director of nursing at St. Luke's Hospital, Boise, Idaho.

John J. Cassidy has been appointed director of public relations at Albany Medical Center, Albany, N.Y.

Miscellaneous

Harold Jaffrey, assistant manager of the Veterans Administration Hospital, Denver, has been appointed director of housekeeping services for the V.A.'s department of medicine and surgery in Washington, D.C.

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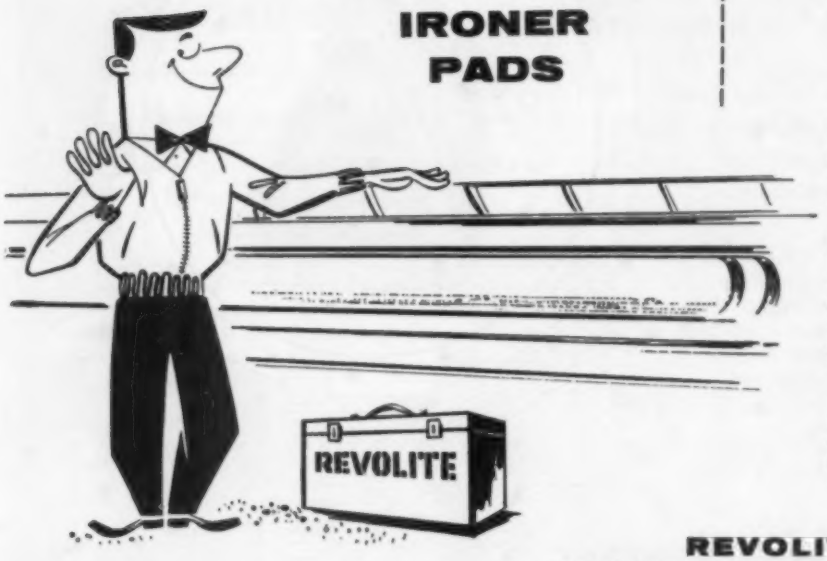
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R/M REVOLON Pads, a blend of asbestos and Dacron,* hold up under today's running temperatures. They keep their resilience longer and dissipate moisture faster because they are made by men who know asbestos and know how to blend it successfully with modern synthetics.

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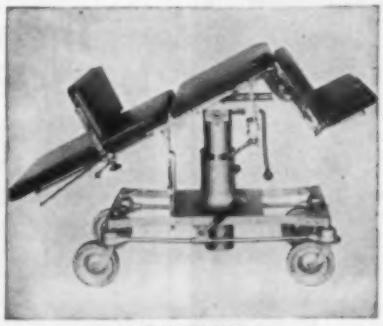
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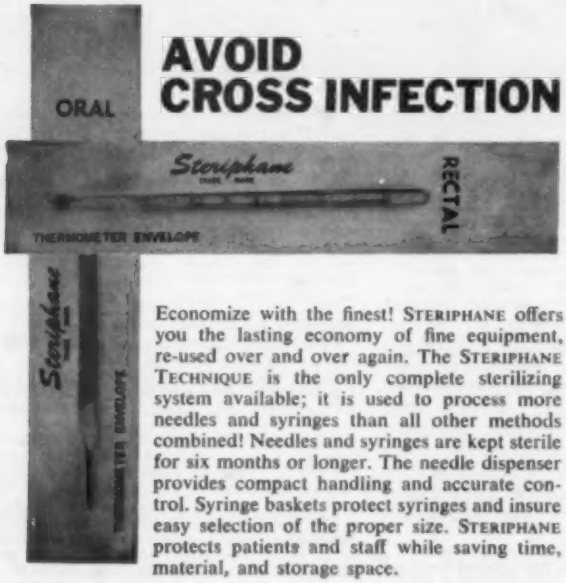
THESE QUESTIONS

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PURCHASING AGENT—15 years, 275-bed eastern hosp; highly recommended; desires to locate in university city; well recommended.

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ANESTHETISTS—Immediate opening for CRNA; 60-bed hospital needs two nurse anesthetists near college town, salary open, paid vacation, sick leave, other liberal benefits. Reply to MO 358, The MODERN HOSPITAL.

ANESTHETIST—Nurse; for 100-bed general hospital to complete staff of three; new, modern air-conditioned hospital located in midwest university town; salary open dependent on qualifications and experience. Write Jack Edmundson, Administrator, DOCTORS HOSPITAL, Carbondale, Illinois.

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ANESTHETIST—Nurse; 54-bed general hospital in S.W. Ohio; expansion planned; salary range: $7200 — $8500, usual benefits, 40 hour week. Apply Administrator, ADAMS COUNTY HOSPITAL, West Union, Ohio.

ANESTHETIST—Nurse; $500, new and modern surgery, unusually strong and well diversified surgical staff; good opportunity in new 260-bed expanding hospital; college town location; good personnel policies, 40 hour week, 7 holidays, hospitalization, social security. Apply F. J. O'Brien, Administrator, CHAMBERSBURG HOSPITAL, Chambersburg, Pennsylvania.

ANESTHETIST—R.N. preferred; seventy-bed hospital, Northwestern Pennsylvania; hospital fully accredited. Write Administrator, COMMUNITY HOSPITAL, N. Fraley Street, Kane, Pennsylvania.

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ANESTHETISTS—Staff; for general hospital; 140-beds; good beginning salary and employee benefits; positions available September 1, 1961. Write for details. ST. ANTHONY HOSPITAL, 1004 N. 10th Street, Milwaukee 3, Wisconsin. c/o Personnel Director.

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(Continued on page 222)

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When you decorate with Pittsburgh COLOR DYNAMICS you create a cheerful, comfortable environment that comforts, relaxes and encourages patients, speeds their convalescence.

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(Continued on page 224)

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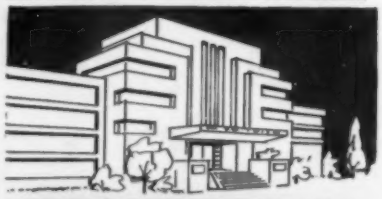
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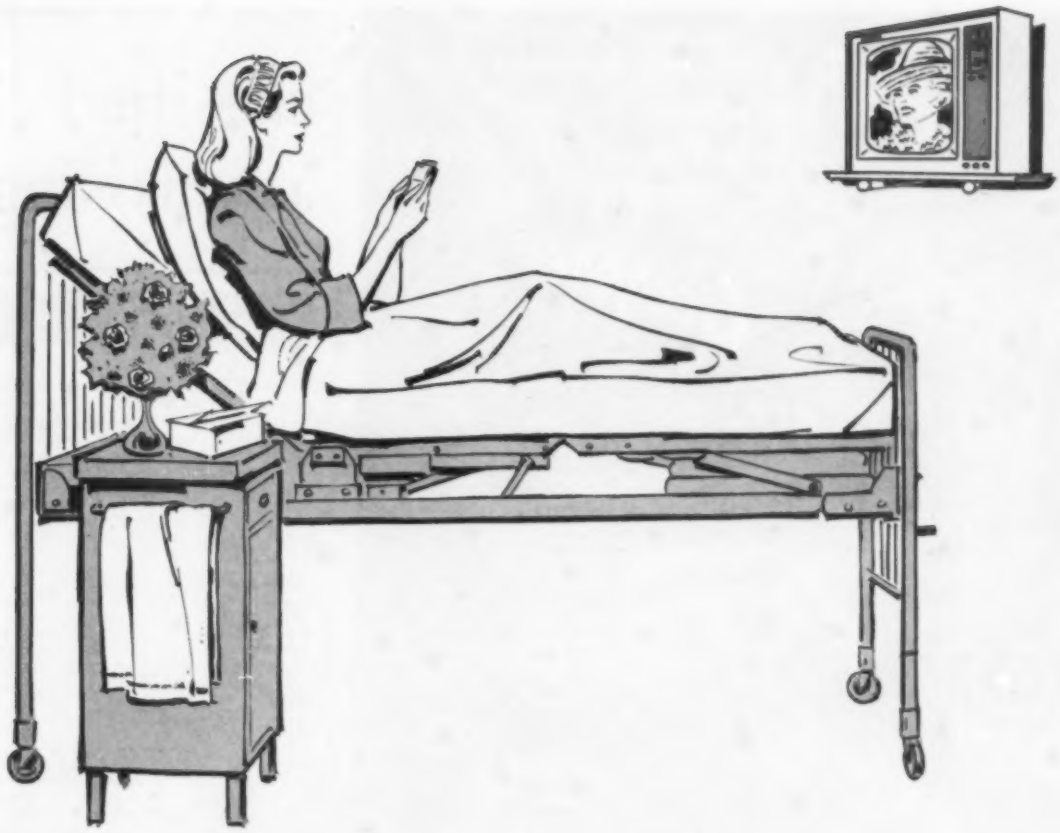
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INSTRUCTOR—In nursing care of children; diploma school; 300-bed hospital close to Baltimore and Washington; Bachelors degree preferred. Apply Director of Nusring, WASHINGTON COUNTY HOSPITAL, HAGERSTOWN, Maryland.

(Continued on page 226)


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LIBRARIAN—Medical records; eligible for registration, to head department within one year, in 115-bed general hospital located on the Sound in southern Connecticut; expansion program. Please send full details on qualifications and training to MO 347; The MODERN HOSPITAL.

LIBRARIAN—Medical records; chief; open; San Francisco Bay Area; 35-bed new general hospital offers opportunity for RRL with experience who desires responsible organizational assignment requiring leadership. BAY AREA MEDICAL ASSOCIATES AGENCY, 870 Market, Suite 563, San Francisco. YUkon 2-6191, Conrad K. Howan, M.S.H.A., Director.

LIBRARIAN—Medical records; an unusual opportunity to set up a medical records system in a new dynamic Mental Health Center; must be registered, and must be well trained and capable; position available immediately; starting salary $405 to $492 depending on qualifications; attractive fringe benefits and working conditions. Contact Personnel Director, FORT LOGAN MENTAL HEALTH CENTER, P. O. Box 188, Fort Logan, Colorado.

LIBRARIAN—Medical record; registered; with supervisory experience for 160-bed 27 bassinet general hospital fully approved by the JCAH and by the AMA for resident training; 40 hour week; salary open and commensurate with ability and experience. Send resume including experience, date available and salary desired to Miss G. A. Cooper, Director, WOMAN'S HOSPITAL, 1940 East 101st Street, Cleveland 6, Ohio.

LIBRARIAN—Medical records; to head department in 500-bed general hospital being expanded to over 600-beds; air conditioned department, excellent fringe benefits, salary open. Apply Personnel Director, The READING HOSPITAL, Reading, Pennsylvania.

LIBRARIANS—Registered medical record; Positions in three of ten general hospitals located in eastern Kentucky, southwestern Virginia, and southern West Virginia, operating on a regional pattern; two positions can be filled by a recent graduate, other position requires 5 years experience for consultative duty to community hospitals in region; salary $4,860 and $5,340 per annum; 40 hour week, 7 paid holidays, 4 weeks vacation, social security, employee health and increment program. Write: MINERS MEMORIAL HOSPITAL ASSOCIATION, Box #61, Williamson, West Virginia.

(LOOKING FOR ADVANCEMENT IN THE NURSING FIELD—SEE PAGE 139)

NURSES—Psychiatric; staff, head nurse and supervisory positions now available; new State Mental Health Center located in a Denver suburb; high nurse-patient ratio; dynamic, interpersonal orientation; nurses an integral part of the psychiatric team; excellent op-

(Continued on page 228)

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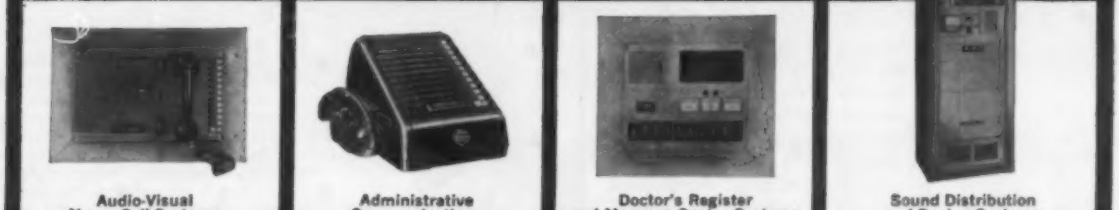
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NURSES—Staff; 455-bed, fully accredited general hospital adjacent to college campus; 40 hour week, 2 weeks vacation, $340 month for 3-11 & 11-7. Apply Director Nursing Service, BALL MEMORIAL HOSPITAL, Muncie, Indiana.

REHABILITATION NURSING—Rehabilitation centers for children and adults; position for staff nurses; top salaries. For information write Director of Nurses, CROTCHED MOUNTAIN FOUNDATION, Greenfield, New Hampshire.

NURSES—Registered; opening immediately; good working conditions, 40 hour week, above average pay in modern air-conditioned hospital. Write or call Wm. C. Brickley, Administrator, PLAINVILLE RURAL HOSPITAL, Plainville, Kansas.

NURSE—Operating room; wanted for 272-bed general hospital; must have OR experience; complete, new, modern operating area consisting of six operating rooms, air conditioned with the latest modern equipment, plus 14-bed recovery room and central sterilizing; execllent salary with one of the finest nurses' personnel policies; beautiful nurses' home with all private rooms nicely furnished. If interested, write or apply DOVER GENERAL HOSPITAL, Dover, New Jersey, c/o C. T. Barker, Director.

NURSES—Registered; men and women; HOUSE OF THE HOLY COMFORTER, non-sectarian hospital-home for chronic diseases, founded 1879, capacity 140-beds, expansion planned; yearly salary range $4200 to $4800 plus meals and uniforms laundered; beginning salary determined on basis of previous experience; excellent fringe benefits; pleasant location, subway and buses at door, 25 minutes to Times Square convenient to three university campuses. For further information address Jeanette H. Fessenden, R.N., Administrator, 2751 Grand Concourse, New York 68, New York. Phone CY 8-8100.

NURSES—Registered; 994-bed Veterans Administration Neuropsychiatric Hospital opening in September; greater Cleveland area; vacancies for staff nurses, O.R. supervisors, night supervisor annual salary based on experience and education from $4,760; liberal employee benefits; new graduates appointed pending registration. Write: Personnel Officer, 10,000 Brecksville Road, Brecksville 41, Ohio.

NURSES—Registered; labor room; general staff duty; all shifts; 3-11 and 11-7 supervisor. Apply Director of Nurses, MARTINSVILLE GENERAL HOSPITAL, Martinsville, Virginia.

SOCIAL WORKER—Medical; to plan and administrater social casework program in relation to hospitalized patients and outpatients; A unique opportunity for someone who possesses vision, enthusiasm, and ingenuity; salary open and extensive benefits. Write to MO 353, The MODERN HOSPITAL.

TECHNICIAN—Laboratory X-ray; for new 31-bed general hospital, A-1 rating, in famous Jackson Hole and Yellowstone Park area; salary commensurated with qualifications and experience. Apply MO 349, The MODERN HOSPITAL.

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TECHNOLOGIST — Medical; immediate opening for male or female, experienced, for 111-bed hospital in beautiful northern New Jersey; new New York City; salary excellent. Apply CHILTON MEMORIAL HOSPITAL, Pompton Plains, New Jersey.

TECHNICIAN—Laboratory; capable of taking X-ray call, A.S.C.P. preferred but not absolutely necessary; pleasant working conditions, lakes area, 45 miles north of St. Paul, Minnesota; light call schedule, paid Blue Cross family plan, top salary for the right person. Contact A. J. Thompson, Administrator, ST. CROIX VALLEY MEMORIAL HOSPITAL, St. Croix Falls, Wisconsin.

(Continued on page 230)

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(Continued on page 232)

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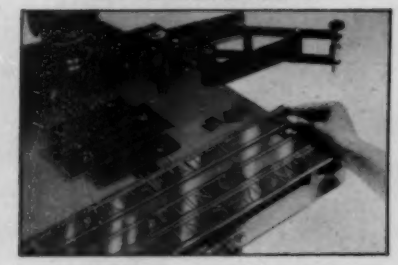
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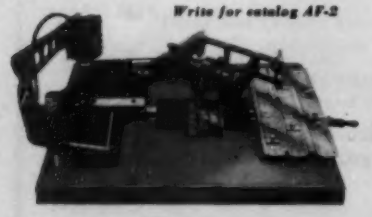
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(Continued on page 234)

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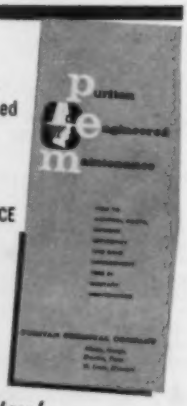
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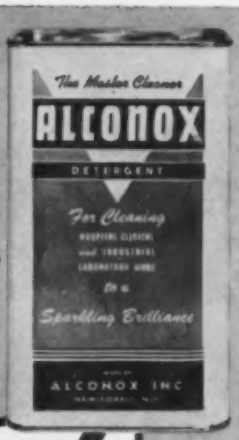
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Provides a new method for the quick and easy application of a sterile, transparent, flexible film, which adheres to the surface of the skin, providing an obstacle to bacteria.

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H & L Spray U.S.P. TINCTURE of BENZOIN *In Aerosol*

Improves adhesive properties of tape and minimizes patient's discomfort during long tape and cast applications. For the prevention of bed sores, we suggest H & L Skin Protector.

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The outstanding sick-room deodorant. Kills odors chemically. Contains no masking agent.

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ASSORTED CASE 2 Cans of each of the above 6 Items **$18.80**

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PSYCHIATRIC POSITIONS WITH MILWAUKEE COUNTY INSTITUTIONS AND DEPARTMENTS in Wauwatosa, Wisconsin, a suburb of Milwaukee:

DIRECTOR OF GUIDANCE CLINIC, $14,490 to $18,071, annually; challenging position directing the activities of dynamic modern, progressive child guidance clinic; med sch grad plus compl of intnshp & psych resdcy; elig for Wis med lic; cert in psych by Amer Bd of Psych & Neurlgy; 2 yrs exper in child psych or 6 mos supvsd wk in child psych during tng; formal application must be filed before 4 p.m., Sept. 28, 1961.

CLINICAL DIRECTOR (Psychiatry), $14,490 to $18,071 annually; desirable opening in mental health center; med sch grad plus compl of intnshp & 3 yr resdcy in psych &/or neurlgy; elig for Wis med lic & cert by Amer Bd of Psych & Neurlgy in Psych &/or Neurlgy; 4 yrs exper in psych &/or neurlgy after compl of reqrd resdcy.

CHILD PSYCHIATRISTS, $14,490 to $18,071 annually; med sch grad plus compl of intnshp & psych resdcy; elig for Wis med lic; cert in psych by Amer Bd of Psych & Neurlgy; 2 yrs exper in child psych or 6 mos spvsd wk in child psych during tng.

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PSYCHIATRIC SOCIAL SERVICE DIRECTOR, $8,014 to $9,479 annually; master's degree in soc wk; 5 yrs exper in psych soc wk incl 2 yrs supvsn. Responsibility for development, direction & co-ordination of psych soc serv prgm at Mental Health Center-North Div. Formal application must be filed before 4 p.m., Sept. 28, 1961.

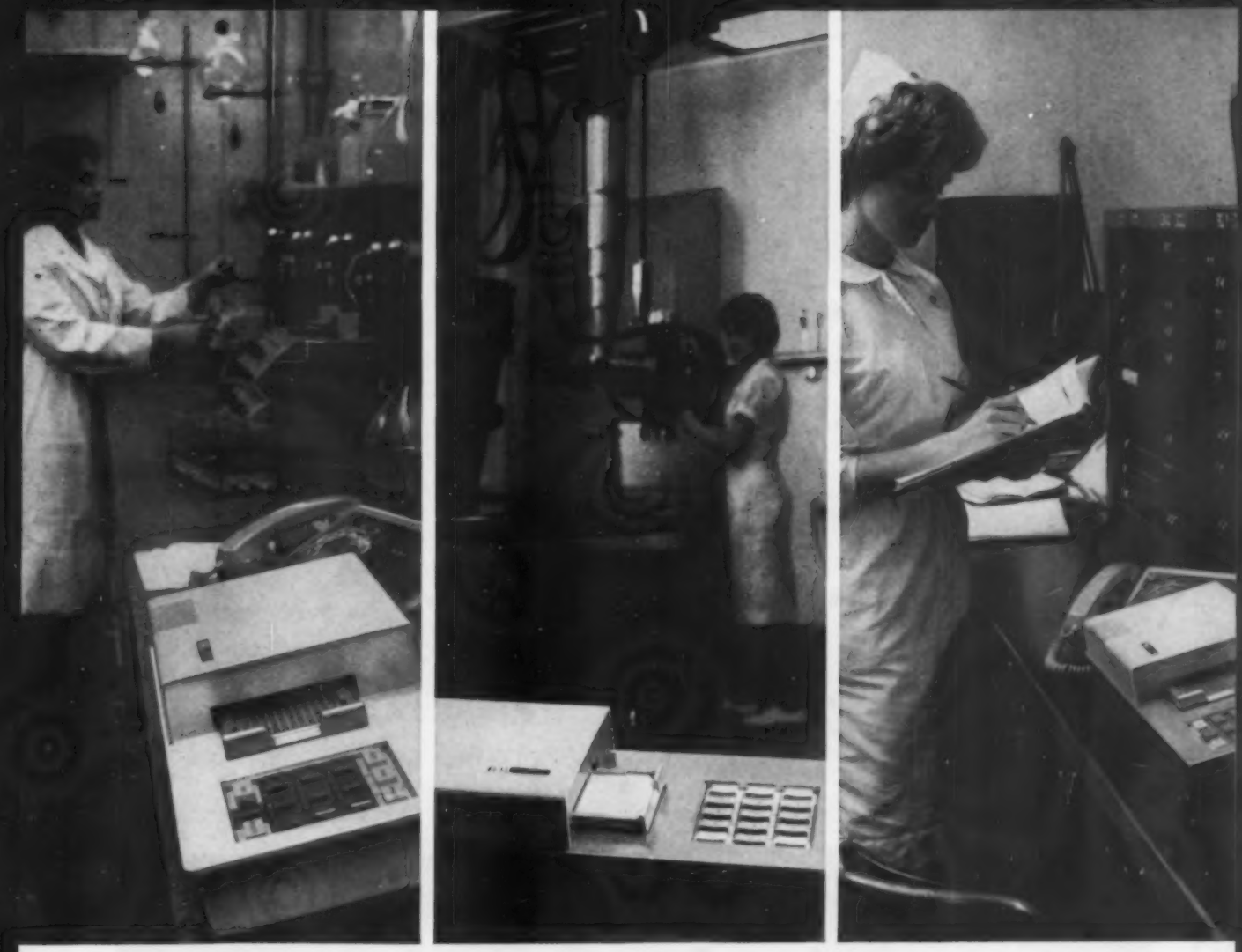
NOTE: Initial salary may be at any step within basic range depending upon qualifications. Attractions: sound retirement plan including social security; liberal paid vacation, holidays, sick allowance, medical & group life insurance plans. Apply: MILWAUKEE COUNTY CIVIL SERVICE COMMISSION, Room 206, Courthouse, Milwaukee 3, Wis. Please request applications by title. Where no final application date is indicated, applications are accepted any time.

OPERATING ROOM SUPERVISOR AND CLINICAL INSTRUCTOR, O. R. Nursing (two positions)
For well-established voluntary 400-bed general hospital with two divisions, each with supervisory assistants and each with a caseload of about 450 operations a month. Seasoned staff of 44 including full-time Clinical Instructor in Operating Room Nursing. Three year diploma program with League accreditation, 100 students. Recovery rooms in each facility.

OPERATING ROOM SUPERVISORY position requires master's degree, five years of experience in operating room including teaching — supervisory responsibility or B.S. degree with equivalent experience and preferably a post graduate course in operating room nursing.

(Continued on page 236)





Now–you can include every charge in the patient's final bill

New IBM TELE-PROCESSING* System speeds charge data directly to your billing department as each charge occurs...using existing telephone lines.

With the IBM 1001, you can prepare final bills faster...have every one complete and up-to-date...reduce collection problems...improve patient relations.

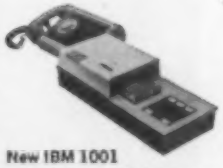
You can put this low-cost IBM TELE-PROCESSING System into operation by locating an IBM 1001 Data Transmission Terminal at activity points—nursing station, laboratory, pharmacy, etc.—and connecting each terminal to existing telephone lines.

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New IBM 1001
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For additional information, use postcard facing back cover.

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MISCELLANEOUS

(Continued from page 234)

CLINICAL INSTRUCTOR, O.R. Nursing requires master's degree, five years of experience in operating room including teaching responsibility or B.S. degree in Nursing Education with experience in teaching operating room nursing.
Registration or eligibility for registration in New York State. Responsible to Director of Nursing and Administrator of Hospital. Well balanced personnel policies include four weeks' vacation, seven paid holidays, two weeks' sick leave and Cumulative sick benefits, pension plan, social security, Blue Cross, group disability and life insurance coverage scaled to salary. Salary dependent upon educational qualifications and experience. Write Director of Nursing, THE ROCHESTER GENERAL HOSPITAL, Northside Division, Rochester 21, New York.

FOR SALE

The "how-to-do-it" series of articles on housekeeping technics, reprinted from the Modern Hospital, is now available in book form. Valuable teaching aid for training housekeeping employes. Write Emily Clagett Deming, 215 Crescent Street, N.E., Grand Rapids 3, Michigan.

SCHOOLS—SPECIAL INSTRUCTION

THE CHICAGO LYING-IN HOSPITAL AND DISPENSARY of the University of Chicago offers a six-month course in obstetric nursing to qualified graduate nurses. The course includes all phases of maternity nursing. The student may elect experience in one special area for two months of the course. Modern, attractively appointed kitchenette apartments are provided. Adequate allowance is made for food and laundry. For further information, write to the Director of Nursing, 3841 Maryland Avenue, Chicago 37, Illinois.

ST. FRANCIS HOSPITAL School of Anesthesia offers to graduates of accredited schools of nursing, an 18 months course in anesthesia. AANA accredited; approved under G.I. Bill of Rights. Stipends offered throughout course. Classes begin April 1 and October 1, each year. Write Sister M. Catherine Ann, O.S.F., C.R.N.A., Director, School of Anesthesia, ST. FRANCIS HOSPITAL, Peoria 4, Ill.

UNIVERSITY OF MICHIGAN offers an 18 month course for nurses interested in anesthesia. Accredited by the American Association of Nurse Anesthetists. Unlimited opportunities for endotracheal intubations, open chest, and neuro surgery anesthesia. Stipend provided. For information write "School for Nurse Anesthetists, UNIVERSITY MEDICAL CENTER, Ann Arbor, Michigan."

MT. CARMEL MERCY HOSPITAL offers an 18 month course in Anesthesiology to registered nurses of accredited schools of nursing. Approved by American Association of Nurse Anesthetists. Stipend provided. Write for complete details regarding theoretical and clinical teaching and requirements for entrance. School of Anesthesia, MT. CARMEL MERCY HOSPITAL, Detroit 35, Michigan.

BARNES HOSPITAL—Offers an 18 month post-graduate course on Anesthesia to registered graduate nurses. Theoretical requirements of the American Association of Nurse Anesthetists met, Miss Helen Vos, R.N., B.S., Educational Director, Clinical training includes all techniques and procedures. Stipend provided. For information, write Mrs. Dean Hayden, Director, School of Anesthesia, BARNES HOSPITAL, St. Louis 10, Mo.

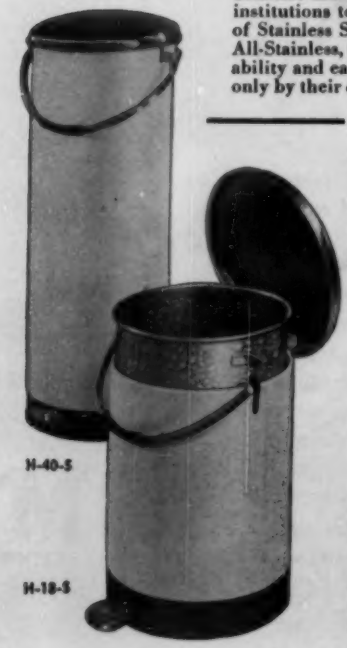
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H-40-S

H-18-S

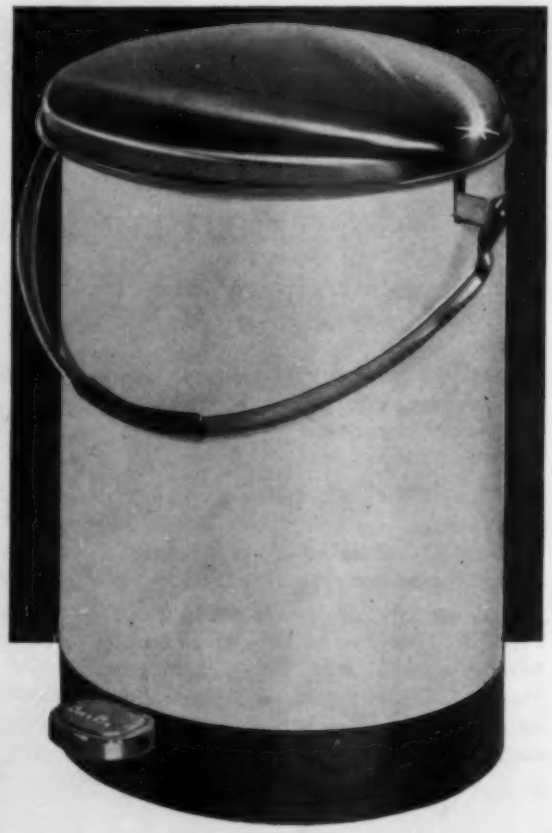
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And only Sanette *"Model H"*, has the patented *dual-purpose handle* that prevents contamination from infectious waste. This single handle, *always outside*, is used to carry the complete receptacle as well as to remove the inner pail.

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They keep the pail clean and are extra tough and non-absorbent because they contain 50% more wax. Insist on the genuine, green Sanette trade-marked bags.



on the one hand
economy

and on the other
surface asepsis
and
durable beauty



Let the Hillyard Hospital Floor Care Consultant prove to you how Hillyard floor treatments, sanitizers and disinfectants effectively control cross-infection, and protect every hospital surface against wear and deterioration... and how in the long run they make for economy. Write us for detailed information on Hillyard Hospital products.

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BRANCHES AND WAREHOUSES IN PRINCIPAL CITIES

WHAT'S NEW

Edited by BESSIE COVERT

LOOK inside back cover for Postage Paid inquiry card for more information.

Zim-Zip Rib Belt
Has Self-Locking Zipper

The Zim-Zip Rib Belt, designed for the treatment of fractured ribs and chest injuries, has an adjustable shoulder strap, and a self-locking zipper, which makes one size fit most patients. **Zimmer Mfg. Co., Warsaw, Ind.**

For more details circle #135 on mailing card.





Plastic Roller
For Conveyor Equipment

A new, low-cost plastic roller for dish rack and other roller conveyor equipment, made of polyvinyl chloride for quiet shock absorbing, has naval bronze ball bearings and stainless steel shafts for strength and rigidity. **Samuel Olson Mfg. Co., Inc., 2418 Bloomingdale Ave., Chicago 47.**

For more details circle #136 on mailing card.

Rectangular Sterilizer
Has Electrically-Operated Door

Several innovations are incorporated into the new Castle Rectangular Sterilizer. The Power Clave has an electrically-operated door which eliminates hand wheels and locking bars. The Castle Electrilock door opens, closes, locks itself and initiates the sterilization cycle at the touch of a button, reducing effort on the part of personnel. In case of power failure, the door can be operated manually. Three safety features prevent opening the door while the vessel is under pressure.

The door is fully insulated to lessen heat loss, and covered by a flat, stainless steel front panel, while the interior surface is of corrosion-resistant nickel. A silicone-impregnated, self-sealing O-ring



seals the chamber under both vacuum and pressure and provides maximum service life. The vessel will accommodate any of the current Castle automatic and manual control systems for steam or ethylene oxide sterilization, or combinations of the two. **Wilmot Castle Co., 1949 E. Henrietta Rd., Rochester, N.Y.**

For more details circle #137 on mailing card.

Kenwood Prims
Are Ready Made Pads

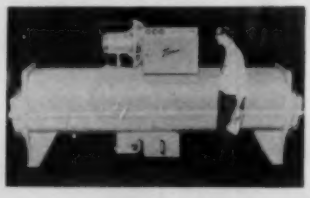
Kenwood Prims, a ready made dressing and cleansing pad for use where the need for a mild, wet dressing is indicated, consist of 3-⅛ inch circles of soft cotton flannel impregnated with cooling, nontoxic witch hazel and glycerine. They are packed in individual white plastic containers for use by nurses, and by patients as a self-care item to save nursing time. **Will Ross, Inc., 4285 N. Port Washington Rd., Milwaukee 12, Wis.**

For more details circle #138 on mailing card.

←

Packaged Tonrac Air Conditioner
Has Reduced Size and Weight

Intended for use as the heart of central station air conditioning systems, providing chilled water for operation of zone or individual room conditioners in hospitals, schools and other institutions, the new American-Standard Packaged Tonrac refrigeration machine features substantial reductions in size and weight. It introduces a major advance in the design of re-



frigeration equipment and has been under development for more than five years. Available in eight size increments from 50 to 100-ton nominal refrigeration capacity, the hermetic centrifugal type unit is completely piped and factory-insulated, and it requires no auxiliary water piping, refrigerant piping or control tubing installation on the job site.

The basic Packaged Tonrac unit consists of a centrifugal compressor with its electric drive motor, a heat exchanger section consisting of condenser and cooler portions, plus necessary piping, valves and controls. Power is supplied from a separate motor-generator-exciter power unit which converts 60-cycle line current to 300-cycle current for the Tonrac motor, and which can be located at the most convenient spot wherever it can be protected from the elements, and not necessarily adjacent to the refrigeration machine. The power unit generator can be operated from any rotary prime mover, permitting use of steam turbines or internal combustion engines as stand-by power sources in the event of an electrical power failure. A major feature of the Packaged Tonrac equipment is reduced floor space, and the completely assembled machine will pass through a standard 36-inch wide doorway. **American-Standard, Industrial Div., Detroit 32, Mich.**

For more details circle #139 on mailing card.

Attractive Occasional Chair
Doubles as Commode

Contemporary design with attractive Naugahyde upholstery in sand color, over



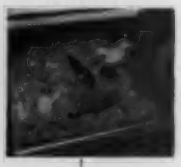
foam rubber, and stained walnut arms and legs make the comfortable Everest & Jennings arm chair fit with any modern decor. When the seat top is removed, a commode is revealed with high-gloss seat and a custom receptacle which is easily removed and replaced. **Everest & Jennings, Inc., 1803 Pontius Ave., Los Angeles 25, Calif.**

For more details circle #140 on mailing card.

Kodak X-Omat Processor Model M-4
Is Compact and Speedy

Designed to meet the time, space and capacity requirements of radiology, the new Kodak X-Omat Processor for rapid processing of screen-type medical x-ray film occupies only ten square feet of floor space. It is also adaptable for use in emergency, surgery, neurology and orthopedic areas in large hospitals. Offering the same seven-minute processing cycle as the larger M-3 X-Omat, the smaller model uses the same roller transport system and the same chemicals developed especially for the X-Omat system. Only the film-feeding end of the Model M-4 needs to be in the darkroom, and the machine has a processing capacity of 100 films per hour. **Eastman Kodak Co., Rochester 4, N.Y.**

For more details circle #141 on mailing card.





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Rubbermaid Utility Scoop
Resists Bacteria

Made of unbreakable plastic, the new Rubbermaid two-quart utility scoop has a bactericide additive which lasts for the life of the product and kills most bacteria causing odors, mildew and mold. It cannot rust, dent or crack, does not scratch or mar surfaces, withstands extremes of cold and heat, and can be steam cleaned. **Rubbermaid, Inc., Wooster, Ohio.**

For more details circle #142 on mailing card.

(Continued on page 241)



A Patient-Safety Program in action!

The O.R. suite, the nursery, the admitting office . . . *all* hospital areas are included in this common-sense approach to the problem of environmental infections, the Patient-Safety Program. Complete facts are on the back of this page. Read them and discover how you and your Huntington representative can design this flexible program to meet the exact aseptic needs of your hospital.

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The Huntington Patient-Safety Program

How to prevent infection from originating in the hospital. That's the problem. Many hospitals are solving it by returning to old-fashioned attitudes toward cleanliness in every department combined with the use of modern, efficient aseptic products. And they are adopting the basic principles of a Patient-Safety Program to set up a common-sense plan-of-attack against resistant Staph. and all other infectious agents.

This practical program features:

- More than 100 Huntington products that will effectively help combat the spread of infection from the admitting office to the O.R. suite, the nursery, everywhere in the hospital.
- An intelligent Huntington representative to help you plan the program to meet your specific needs. Individual hospital aseptic problems differ because of variations in layout, in function and in use. The job of the Man behind the Huntington Drum is to select the right Huntington product or products for your hospital. He will show you how to efficiently and effectively use these products to destroy bacteria on all surfaces.
- An experienced Huntington representative whose advice and suggestions will greatly assist you while building and maintaining your Patient-Safety Program. His experience in the hospital aseptic control field averages 19 years.
- A company that completely backs up its men and products with research laboratories that place quality above all else. For over 41 years, these laboratories have been enforcing rigid control over the Huntington manufacturing processes.

Call or write today. Get more details on the Huntington Patient-Safety Program.

Two Huntington products to help you prevent cross-infection:

- **GERMA-MEDICA LIQUID SURGICAL SOAP WITH HEXACHLOROPHENE** • Reduces bacteria on the skin well below safe levels. Tests have proved its bacteriostatic efficiency. Keeps hands soft and smooth. Ideal for the surgeon's prep and for use at all hospital stations. Germa-Medica with Hexachlorophene is highly concentrated. It is diluted with up to four parts water per one part soap for very economical use.
- **SAN PHENO X . . . A HIGHLY BACTERICIDAL GERMICIDE** • For general-purpose hospital disinfecting. Has a broad bacterial spectrum. Highly effective against Resistant Staph. Easy to use, has a pleasant odor. Will not irritate skin or stain or corrode metal when used as directed. Economical.



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- ☐ Please send me the free booklet, "A Suggested Plan for Infection Control in Hospitals."
- ☐ Send more information on Germa-Medica Liquid Surgical Soap with Hexachlorophene.
- ☐ Send laboratory reports and other literature on San Pheno X Germicide.
- ☐ Have your representative call for an appointment.

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CITY _____ STATE _____

Colson Premature Incubators Control Oxygen Concentration

Two new Colson incubators for premature infants feature control of oxygen concentration and are designed to facilitate crib cleaning, prevent possible accidents and eliminate frequent heat source replacement. Instrument panels lift off with removal of two screws for easy access to controls, and a safety high-limit thermostat prevents heat rise above 100 degrees F. even if the manually controlled thermostat should become inoperative for any cause.

The Freehand Model 4B102 provides free access to infants without appreciable loss of oxygen and ensures against Ret-



rolental Fibroplasia. It features visible five-day water supply; four-wall distribution of radiant heat, humidity and oxygen; separate heating and humidifying cabinet; direct reading indicators, and excellent observation for all normal viewing angles. An access door allows maximum freedom in infant care while retaining the existing climatic conditions. **The Colson Corp., 7 S. Dearborn St., Chicago 3.**

For more details circle #143 on mailing card.

Heinz Chef-Size Soups Have Yield Chart on Label

Designed to provide a quick and accurate reference for the dietitian and others responsible for food service, Heinz Chef-Size Soup cans now have a yield chart on the label. The number of savings, in three sizes, per can and per case, are charted to aid in portion control. Other information provided includes directions for preparation, suggestions for menus, and a special soup recipe. **H. J. Heinz Co., Box 57, Pittsburgh 30, Pa.**

For more details circle #144 on mailing card.

China-Clipper Dish Carrier Permits Rugged Use

The China Clipper is a new heavy duty dish carrier for heavy loads in institutional food service. Constructed of large stain-



less steel, angle formed to withstand shocks and loads, the carrier glides easily on large casters, is impervious to food greases and acids, and is easy to clean and maintain. **Bloomfield Industries Inc., 4546 W. 47th St., Chicago 32.**

For more details circle #145 on mailing card.

G-E Closed-Circuit Monitors for Improved Viewing

Engineered to provide maximum brightness, stability and detail over the entire viewing area, the new series of electronic closed circuit television monitors is simple to maintain and adjust, and provides easy accessibility to all parts. The units operate with any standard monochrome camera and are offered in cabinets or rack mounting in three screen sizes. Size, focus and linearity controls are operated individually and adjustment of one has no effect on the others, due to an advanced design technic. The new monitors are designed for use in hospitals for monitoring x-ray treatments and surgical procedures, and for other closed circuit uses. An accessory polarized safety glass faceplate is available for additional effective-



ness in minimizing reflections and improving contrast ratio. **General Electric, Communication Products Dept., Syracuse, N.Y.**

For more details circle #146 on mailing card.

(Continued on page 242)



Style 9319MC
Double Breasted
Slip Over
with Cape Shoulders
and Mitten Cuffs

Rubens Wear for INFANT CARE



Style C-316MC Tie Vest.
Reinforced Shoulder
Seams, Mitten Cuffs

Baby's safer and more comfortable with Rubens special mitten cuff to protect against face scratching. Your budget is protected, too, because Rubens garments are more durable—cut replacement costs.

Rubens Infant Wear is available in a wide range of styles and sizes for maximum economy and convenience. To learn how Rubens garments can save money for your nursery, **send for free Infant Wear Buyer's Guide today**

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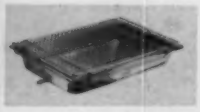
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New York Sales Office
71 W. 35th St., New York, N.Y.

Odor-Removing Filter Is Economical and Disposable

An economical, effective method for removing odors is offered in the new Dacor Filter which is fully disposable, has activated charcoal fiber strips and is easily installed, without mechanical changes. **Barnebey-Cheney Co., Cassady at Eighth, Columbus 19, Ohio.**

For more details circle #147 on mailing card.





Portable Debridement Tray Has Removable Rigid Wire Top

Designed for cleansing and treatment of arm and leg wounds, the new Weck portable Debridement Tray and its removable rigid wire top are made of stainless steel. A spring catch holds the top in closed position, and a special tubing outlet permits continuous solution drainage. The tray is designed for use in operating and emergency rooms. **Edward Weck & Co., 135 Johnson St., Brooklyn 1, N.Y.**

For more details circle #148 on mailing card.

Liquid Synthetic Cleaner Has Foam-Inhibiting Additive

A foam-inhibiting addition known as LF-7 makes the new fast-acting liquid "Lo-Foam" synthetic cleaner produce very little foam. Foam which is generated breaks down and disappears in a matter of seconds, cutting down on mechanical delays in the vacuum pick-up. Lo-Foam is safe for use on all types of floors and gives excellent results in cleaning walls, windows, plastic, furniture, metal doors and partitions. **Multi-Clean Products, Inc., St. Paul 16, Minn.**

For more details circle #149 on mailing card.

PBX Dictation System Introduced by IBM

The IBM "Executary" dictation equipment employs fully transistorized products, with recording done on a reusable magnetic belt. The belt holds 14 minutes of recording and can be mailed, filed or stored. The new system can be connected to any automatic dial PBX or PAX switch-



board through telephone company furnished links. Operation is controlled through a regular dial telephone, eliminating the need for additional desk instruments for dictation. **International Business Machines Corp., 545 Madison Ave., New York 22.**

For more details circle #150 on mailing card.

Waste Disposer Line For Varied Operations

The broad new line of Waste King Universal commercial food waste disposers ranges from Model DK for small kitchens to the SPD-3 Model, capable of disposing of as much as 1800 pounds of rib bones per hour. The improved models offer up to twice the grind rate and more than double the service-free life expectancy of previous units. The seven basic disposers and accessories may be assembled in 170 combinations to meet specialized requirements. **Waste King Corp., 3300 E. 50th St., Los Angeles 58, Calif.**

For more details circle #151 on mailing card.

Stairmaster Safety Treads For Worn, Slippery Stairs



Developed as an easy method for updating worn, slippery stairs, the new Super Stairmaster aluminum safety treads are nine inches wide with a beveled back, and fit all steps up to 13 inches wide. **Wooster Products Inc., 1000 Spruce St., Wooster, Ohio.**

For more details circle #152 on mailing card.

(Continued on page 244)

Another RLP 20th *Anniversary Development*



PURE LATEX SURGICAL TUBING

NOW REEL-PACKED in 12 STANDARD SIZES

for your greater convenience and wider application

I.D.		WALL		I.D.		WALL	
1/8	x	1/32		3/16	x	3/32	
1/8	x	3/64	NEW	1/4	x	1/16	
1/8	x	1/16	NEW	1/4	x	3/32	
1/8	x	3/32	NEW	1/4	x	1/8	NEW
5/32	x	3/64	NEW	5/16	x	1/16	
3/16	x	1/16		5/16	x	3/32	NEW

World Suppliers

These 12 standard sizes are packed in 50-foot units on handy reel dispensers. Other sizes, available on special order, are packed in boxes in 12-foot lengths.

RLP RUBBER LATEX PRODUCTS, INC.
SPECIALISTS IN PURE LATEX TUBINGS SINCE 1941
CUYAHOGA FALLS, OHIO

ANY WAY
YOU LOOK
AT GRANT'S
CUBICLE
CURTAIN
HARDWARE,
YOU'LL SEE
THE FINEST!
HIGHEST
IN QUALITY■
SMARTEST IN
APPEARANCE■
MOST
CAREFULLY
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HOSPITAL
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PERFORMANCE■
DESIGNED
FOR CEILING
OR SUSPENDED
INSTALLATIONS
AND
ECONOMY-
PRICED TOO!



Write for price list and catalog on Grant's full line of cubicle track and curtains

GRANT HOSPITAL CUBICLE HARDWARE

GRANT PULLEY & HARDWARE CORPORATION / EASTERN DIVISION / 69 HIGH ST., WEST NYACK, N.Y. / WESTERN DIVISION / 944 LONG BEACH AVE., LOS ANGELES 21, CALIF. / **FACTORY REPRESENTATIVES IN MAJOR CITIES**

Economical Trans-Shelf For Semi-Active Files

Economical and versatile, the new Trans-Shelf files offer easy accessibility, permanent protection, and quick filing of active records which are too outdated to take up space in current files, but still must be available for occasional reference. **Record Files Inc., P.O. Box 581, Wooster, Ohio.**

For more details circle #153 on mailing card.

"Cable Wire" Suture Ties Like Silk

Composed of several strands of specially treated stainless steel wire twisted together to produce a smooth, slender suture of maximum strength and a high degree of flexibility, "Cable Wire" ties like silk. It is introduced for use in all types of surgery and for anchoring mesh. It does not prick or puncture since the multiply strands flex away from tissue. **United Surgical Supplies Inc., Port Chester, N.Y.**

For more details circle #154 on mailing card.

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Ansco-File for Routing Films Holds up to 25 X-Rays

Offering an efficient method of handling x-ray films and patient records during the routing course of diagnosis, the new Ansco-File of durable, stain resistant plastic material, holds up to 25 films and has an acetate window pocket for identification. The portable file was developed for the radiology departments of hospitals and holds both the x-rays, in the clear acetate half sleeve in front of the folder, and the patient's records, while radiographs taken previously are inserted inside the file. The Ansco-File is then placed in the viewing room for the radiologist. Other uses to facilitate handling and care of films are possible, with increased accuracy and elimination of mix-ups. **Ansco Div., General Analine & Film Corp., 32 Charles St., Binghamton, N.Y.**

For more details circle #155 on mailing card.

Paging System Is Easy to Use

A new easy-to-use audible paging system called the Lokator, designed to page



key personnel wherever they are needed in a hurry, features foolproof operation, automatic paging, designer styling and rugged construction. **Edwards Co. Inc., Norwalk, Conn.**

For more details circle #156 on mailing card.

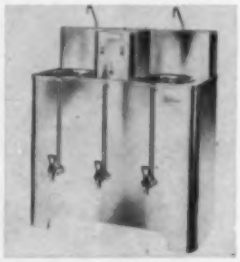
Vapor Phase Now in Aerosol Pack

Vapor Phase, to keep surgical instruments rust-free during autoclaving and in storage, is now supplied in a new aerosol container for more uniform wetting of packaged instruments with less waste. **Lorvic Corp., 5553 Eastern Ave., St. Louis 12, Mo.**

For more details circle #157 on mailing card.

Twin-10 Coffee Maker Is Completely Automatic

The improved 20-gallon capacity Twin-10 Coffee Maker automatically delivers the correct amount of water at the proper temperature to make uniformly good drip coffee with speed and simplicity. Push-button operation gives the required brew



in only two steps. **Best Products Co., 2620 W. Addison, Chicago 18.**

For more details circle #158 on mailing card.

(Continued on page 246)

HAVE YOU LEARNED WHAT THOUSANDS OF NURSES KNOW?

BIG D

is the only deodorant that can handle

TERMINAL CANCER ODORS



A TYPICAL HOSPITAL REPORT

"Big D Deodorant has been especially helpful in combatting odors in the rooms of cancer and burn cases, odors which no other deodorants we have tried have eliminated successfully."

ASK YOUR HOSPITAL OR JANITOR SUPPLY COMPANY



GET YOUR FREE SAMPLE—USE THIS COUPON

LaFevre Chemical Company
1708 West Main Street, Oklahoma City, Okla.
Please send 1 oz. sample BIG D, hospital-proved deodorant.

INSTITUTION_____

BY_____

CITY_____ STATE_____

PURAPHEN®

Accepted for Hospital Use

The Most Effective Cleaner-Germicide You Can Use



WHY IS PURAPHEN A SUPERIOR CLEANER?

PURAPHEN is a *built* detergent; a high sudser with a pleasant odor. Its *balanced blend* gives PURAPHEN maximum cleaning efficiency, greatest economy. For example, PURAPHEN removes dirt, grime, dull soap film and old wax from the invisible pores as well as from the surface of any floor. And through emulsification and suspension keeps the dirt from settling back on the floor. Dirt is rinsed away freely, yet PURAPHEN leaves no sticky deposit or dulling film. *Approved by Underwriters Laboratories for use on conductive floors.*

Proved Performance

- ✔ Effective Against Escherichia coli (urinary tract infections)
- ✔ Effective Against Salmonellacholeraesuis (food-poisoning outbreaks)
- ✔ Effective Against Virulent Tubercle Bacilli (Tuberculosis infection)
- ✔ As a Fungicide, Effective Against Trichophyton interdigitale ("Athlete's Foot")
- ✔ Microsporum gypseum ("Ring Worm" of skin and scalp)
- ✔ Epidermophyton floccosum ("Athlete's Foot")
- ✔ Candida albican's (foot, mouth and vaginal infections)
- ✔ Effective as a Bacterial Sporicide against spores of Bacillus subtilus and Clostridum tetani (tetanus bacillus)
- ✔ Effective Against Pyogenic and Enteric Bacteria
- ✔ Effective Against Salmonella typhosa (typhoid bacillus)
- ✔ Effective Against Staphylococcus aureus (staph infections—abscesses, boils, pimples)
- ✔ Effective Against Streptococcus fecalis ("strep" infections)
- ✔ Effective Against Pseudomonas aeruginosa (Bacillus of green pus)
- ✔ Effective Against Proteus vulgaris (Ear and chronic infections)



LIQUID SURGICAL SOAP

ANASEP — 40% Solids, contains Hexachlorophene. A delicately adjusted formula containing the finest vegetable oils. Low pH. Superfatted to leave skin soft. Reduces skin bacteria 97% in 5 days. Pleasantly scented-green in color.

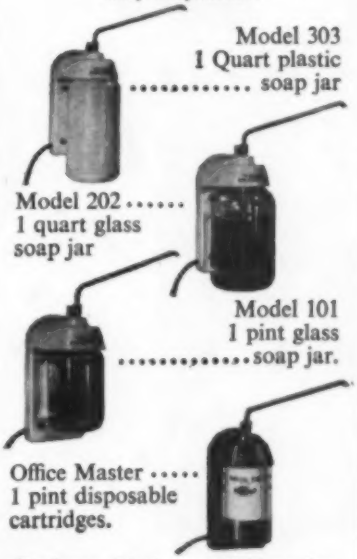
ASEPTEX — 40% Solids, contains Hexachlorophene. A balanced formula containing Lanolin and other skin emollients. Low pH. Reduces resident skin bacteria 97% in 5 days. Pleasantly scented-red in color.

ASEPTROL — 20% Solids, contains Hexachlorophene. Same as Aseptex except diluted for dispenser use.

U. S. P. TINCTURE of GREEN SOAP. High quality vegetable oil soap combined with specially denatured alcohol. Conforms to U.S.P. specifications. Used for treatment of skin disease and also for shampoo.

PED-O-FLO

Foot Operated Liquid Soap Dispensers



Model 303
1 Quart plastic ..... soap jar

Model 202 .....
1 quart glass soap jar

Model 101
1 pint glass .....soap jar.

Office Master .....
1 pint disposable cartridges.

Conforms with the most rigid requirements of surgical asepsis

HOSPITAL DISPENSER STAND

All Chrome — Low Cost Portable Surgical Soap Dispenser

Attractive stand has heavy non-tip non-slip base. Three hard rubber cleats attached to base insures a steady wobble-free performance.



Weighing less than 8 pounds it can be easily lifted and moved with one hand by a nurse.

The heavy chrome plating produces an attractive appearance and is especially easy to clean . . . also there is no danger of rusting.

This low cost stand has been designed for use with Ped-O-Flo dispensers.

PECK'S PRODUCTS CO.

610 E. CLARENCE • ST. LOUIS 15, MISSOURI

Gentlemen:

☐ Send prices and information on_____

☐ Have representative call.

NAME _____

FIRM _____

STREET _____

CITY _____ ZONE ____ STATE _____

For additional information, use postcard facing back cover.

Self-Closing Faucet for Distilled Water

A new positive-action self-closing faucet, which prevents loss of distilled water



and maintains its purity at point of use, will not leak or drip. **Barnstead Still & Sterilizer Co., 124 Lanesville Terrace, Boston 31, Mass.**

For more details circle #159 on mailing card.

Flipstik With Cleanser Saves Time and Detergent

A cleanser formula, specifically designed for the new Flipstik cleanser-applicator, contains a reverse viscosity liquid principle which, with the "Magic Measure" monitoring valve on the Flipstik, prevents cleanser waste. Just one ounce of the cleanser, used as directed in the rugged heavy duty plastic Flipstik, will enable a housekeeping maid to clean 15 bathrooms without scouring materials. Odorless, solvent-free and non-flammable, the cleanser can be used on paint and other fine surfaces without harm.

For introduction to institutional housekeeping, Flipstik is offered in the washable plastic Flip-Pak carryall with extendable flaps and containing two applicators, two bottles of cleanser, one bowl brush and one star-shaped abrasive head. The Flipstik cleanser-applicator itself adapts



to interchangeable brush or sponge heads, each with a different type of abrasive coating. **Leisure Devices, Inc., 1161 York Ave., New York 21.**

For more details circle #160 on mailing card.

OUTSTANDING *Flexibility* AND *Efficiency*

SCHWARTZ SECTIONAL SYSTEM FOR HOSPITAL PHARMACIES

Made in Grand Rapids, Michigan by Grand Rapids Craftsmen



SCHWARTZ Top Unit No. 20 Base Unit No. 1 Top Unit No. 16 Base Unit No. 6

For more than 50 years, the name GRAND RAPIDS has personified all that is best in pharmacy planning and equipment. From coast to coast stretches an imposing and steadily increasing number of GRAND RAPIDS equipped pharmacies — leaders, invariably, in their communities.

The illustration above shows how all sizes of containers, from a small vial to a gallon bottle inclusive, can be conveniently carried for easy accessibility.

Manufactured Solely and exclusively by

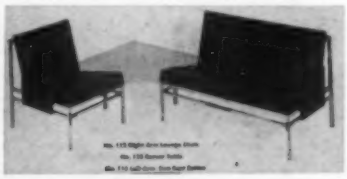
GRAND RAPIDS SECTIONAL EQUIPMENT CO.

GENERAL OFFICES: 200 FULLER BLDG., 11 FULLER AVE., S. E.

GRAND RAPIDS 6, MICHIGAN • PHONE GL-1-3335

Modular Seating Group Features Adaptability

Designed to fill almost any type of lounge or reception room seating requirement, the Royal Modular Seating Group consists of a lounge chair and two-seater settee, both of which are available with one or two or no arms. The Royalwood table tops in three rectangular sizes can



be ordered with attachments, such as a built-in planter or ashtray. Cushions are Naugahyde or Super Tuftex over foam rubber, and the sturdy steel frames have welded joints and chrome finish. **Royal Metal Co., 1 Park Ave., New York 16.**

For more details circle #161 on mailing card.

Leitz Model M Photrometer Handles 40 Measurements

Approximately forty vital diagnostic measurements of blood, serum, urine, spinal and other body fluids can be made with the new Leitz Model Photrometer. A photo-electric current is transmitted to a highly sensitive meter, which reads both in per cent transmitted and optical density. Mirror-backed scales eliminate parallax. A new cuvette holder accommodates three sizes, including those for a minimum volume of less than one ml of colored solutions, making the Leitz Photrometer also suitable for tests on children and infants. The new micro ammeter has a long-



er scale for easier reading. **E. Leitz, Inc., 468 Park Av. S., New York 16.**

For more details circle #162 on mailing card.

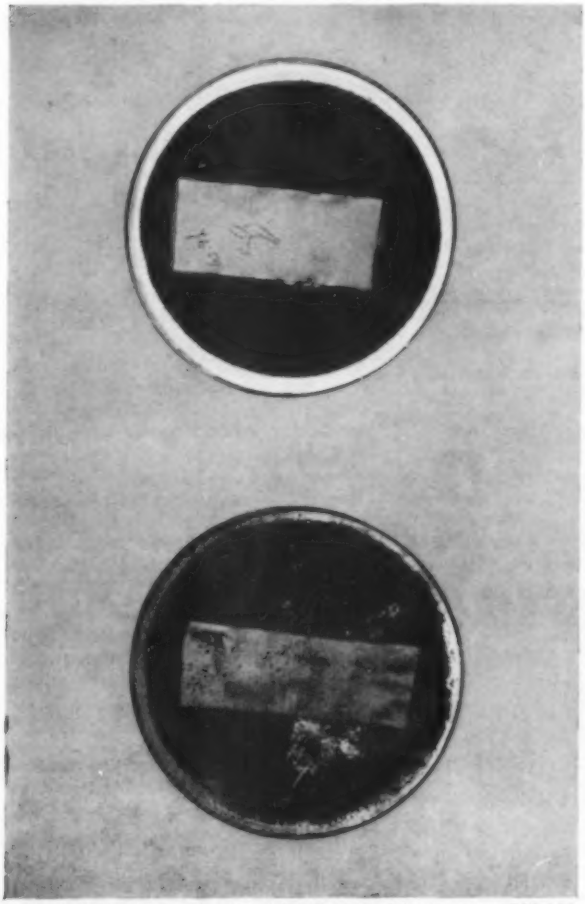
(Continued on page 248)

Which is your most sanitary window treatment?

Flexalum Twi-Nighter blinds are the most sanitary, and easiest-to-keep-sanitary window covering. Flexalum plastic tapes deter bacteria because there are no loose fibers or porous surfaces to absorb dirt as there are in fabric tapes. (See test below.) And Flexalum wipe-clean tapes won't fray, fade, stretch or shrink. Twi-Nighter blinds are made with a special nylon cord that has a harder, smoother, more sanitary surface than cotton cord. Flexalum's spring-tempered aluminum slats have a baked finish of enamel and emulsified wax that makes them exceptionally smooth and soil resistant. They won't rust, chip, crack or peel. You have the protection of a written five year guarantee by Bridgeport Brass Company.

Flexalum®

What's more, with Flexalum Twi-Nighters you can give your patients maximum range of light control — from soft diffused daylight to complete darkness. Write us today for free literature, or name of your nearest Flexalum dealer. He'll be glad to give you cost estimates at no obligation. Bridgeport Brass Company, Hunter Douglas Division, 30 Grand Street, Bridgeport 2, Connecticut.



In Bacteria Test (directly above) fabric tape picked up over 700,000 bacteria per square inch. Flexalum wipe-clean plastic tape (top) picked up only 100 bacteria per square inch.* *Gar-Baker laboratory test.



Easy-to-clean Flexalum Twi-Nighter blinds give complete light control, let patients rest during even the brightest, sunniest days because they close tighter than ordinary blinds.

BOWLS THEM OVER!



Jiffywhite Takes the Stain and Pain out of Toilet Bowl Cleaning!

Try the free quart of Jiffywhite and Mop, offered below. See for yourself how Jiffywhite's amazing sudsing action quickly removes the toughest stains. Discover how easy and pleasant Jiffywhite is to use. It has a pleasant aroma, is completely non-toxic and non-poisonous. It CLEANS, DEODORIZES, DISINFECTS. You'll find it ideal for cleaning any porcelain or ceramic tile surface. The price, like Jiffywhite, is easy and pleasant.



TIME for Cleaning!

As the new home of Jiffywhite, Time Chemical, Inc. is proud to add this outstanding product to its own popular line of Time-Saver detergents and scouring cleansers. We want to assure you that your Jiffywhite and Time-Saver products are backed by manufacturing facilities, laboratory control, and a technical staff unexcelled in this field.

TIME
CHEMICAL, INC.

— FREE OFFER! —

TIME CHEMICAL, INC. Dept. 9-C
3950 S. Karlov Ave. Chicago 32, Illinois

Please rush me my free quart of Jiffywhite and Mop at no obligation to me.

Name _____ Title _____
Company _____
Address _____
City _____ Zone _____ State _____

Ease and Comfort at Low Cost With Beautyrest Dorm Lounge

Attractive, efficient living-study rooms for student nurses are possible at minimum cost with the new Beautyrest Dorm

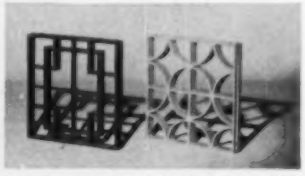


Lounge, offering comfort in sitting, sleeping and use, as the bed rolls out smoothly to any position for ease in bed making. **Simmons Co., Contract Dept., Merchandise Mart, Chicago 54.**

For more details circle #163 on mailing card.

Ornamental Grillework Now Offered in Matching Colors

The attractive styrene ornamental grillework known as FiliGrille is now factory painted to specifications in a wide choice of enamel colors, in addition to standard metallic paint colors of gold-brass, cop-

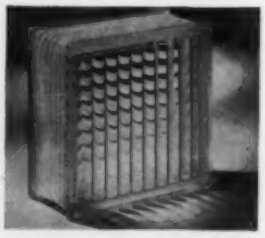


per and aluminum. Color can be molded into FiliGrille on special orders. The attractive material is formed in open work blocks chemically welded together to form strong panels of any desired size. **Holcomb & Hoke Mfg. Co., Inc., Dept. 781, 1545 Van Buren St., Indianapolis 7, Ind.**

For more details circle #164 on mailing card.

Color-In-Glass Blocks Added to Patterns

The smooth-faced glass block with convex ribs on both interior faces, giving a high degree of light transmission with a fair degree of privacy, is now offered with color. "Shade Aqua" adds an attractive,



delicate blue-green tone to light transmitted through the block, now known as number 316-A. "Shade Green" is the designation of the functional, daylight control glass block with color. **Kimble Glass Co., subsidiary of Owens-Illinois, Toledo 1, Ohio.**

For more details circle #165 on mailing card.

(Continued on page 250)



More Hospitals Use STARTEX® SURGICAL TOWELING than any other kind!

In Operating and Delivery Rooms . . . where only the best is good enough . . . STARTEX Surgical Towelings provide the absorbency and serviceability you need.

STARTEX Double Dent Surgical Towelings are constructed to assure *uniformly-balanced* higher tensile strength. Unrivaled for softness and absorbency, they launder superbly. In white, jade green, misty green, steel grey, and cadet blue. Also available: Traditional STARTEX Toweling, 2-ply in both warp and filling.

See your STARTEX Distributor or write for descriptive new Swatch Sheet.



- Kitchen towels and toweling
- "Hospital Property" Huck towels
- Damask tray covers
- Scarfing

STARTEX®

STARTEX MILLS, 55 Worth Street, New York 13, New York

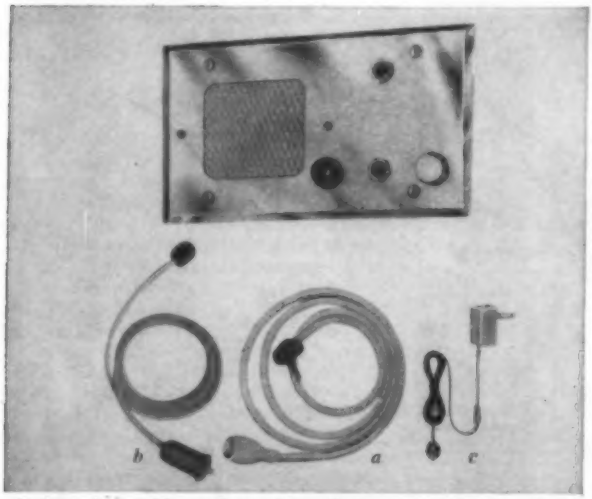
Standard of Excellence for 3 Generations



▲ *The patient may talk to the nurse—even whisper—from any position in her bed.*



▲ *The nurse may talk to patients from her station, monitor their rooms, cancel their signals.*



▲ *Interchangeable cord sets for calls from: a. normal patients; b. patients who cannot speak or hear; c. oxygen-tent patients.*



▲ *Remote reply units enable the nurse to accept calls and talk to patients from locations away from her station.*

AUTH NURSES' CALLING SYSTEMS

Can Tremendously Benefit Your Hospital

Statistics show that a modern nurses' calling system, properly installed and properly used in your hospital, will greatly increase the nurses' effectiveness through saved footsteps, ability to take care of more patients, greater concentration on direct bedside care, and increased morale and feeling of accomplishment. This offers the tremendous benefits to the hospital of greater staff efficiency and service, reduced operating costs, more and speedier recoveries, and increased goodwill.

To obtain these benefits you will want not *any* nurses' calling system but the best—Auth. And Auth is best because it reflects over forty years of experience in this field; because it is deliberately simplified to make it easy to understand and use; because its design minimizes installation costs.

You can specify Auth nurses' calling systems for your hospital with confidence—and Auth doctors' in-and-out register and paging systems. A representative is ready to discuss them with you. Please call upon us. No obligation.

Auth SINCE 1892

Auth Electric Company, Inc.

LONG ISLAND CITY 1, NEW YORK

Disposable Circumcision Device
Now Individually Pre-Sterilized

The disposable Plastibell, for at-birth circumcision in just two or three minutes, is now supplied in individual gas-sterilized packets for delivery room use. Each pre-sterilized packet will contain one Plastibell and one linen suture. Plastibells come in three sizes, require no sterile pack in use, and minimize the possibility of bleeding. **Hollister Incorporated, 833 N. Orleans St., Chicago 10.**

For more details circle #166 on mailing card.

Soap Dispenser
First in Recessed Line

Models B 310 and B 315 for dispensing soap in liquid and lather forms, the first models in the new Bobrick "Bob-Recessed" line of washroom equipment, help to thwart vandalism through a special keyed lock-cap. **Bobrick Dispensers Inc., 1839 Blake Ave., Los Angeles 39, Calif.**

For more details circle #167 on mailing card.

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Dispos-A-Glove
Has Improved Fit and Strength

Improved fit, greater comfort and increased strength are features of the entirely new and redesigned Dispos-A-Glove, the General Purpose Disposable Glove of polyethylene. It is suited for use in the laboratory, kitchen, laundry or wherever low-cost hand and patient protection are needed, including use by physicians for examination and for changing dressings. It is an inexpensive five-finger glove in small, medium and large sizes, offered in a small, convenient dispensing package, with each glove enclosed in paper. **Arwood, Somerville, N.J.**

For more details circle #168 on mailing card.

Valclene Fluid
Provides Safe Dry Cleaning

Valclene dry cleaning fluid, based on fluorocarbon, is a Du Pont product developed to clean garments in coin-operated dry cleaning machines in 15 minutes. Improved safety is a special feature of the cleaner, which is non-flammable and odorless. **E. I. Du Pont de Nemours and Co., Inc., Wilmington 98, Del.**

For more details circle #169 on mailing card.

Colostomy Training Device
for Nurses and Patients

Designed for training nursing students, patients and their families, the colostomy irrigation kit has three plastic moulages. One is a temporary colostomy, another reveals the stoma in final form, while the third represents the stoma with an infection at its base. The special molded plastic is colored and textured to simulate skin, stomas, scars and sutures and may be strapped to a nursing technics doll or to a living demonstrator. A plastic water bag with flexible tubing connects to the inside of the stomas so that each of the three colostomies may be irrigated as in actual patient care. **Alderson Research Laboratories, Inc., 48-14 33rd St., Long Island City 1, N.Y.**

For more details circle #170 on mailing card.

Code-Punched Cards
Simplify Composition of Listings

Edge Card Punch and Edge Card Reader are now available for the Justowriter



automatic tape-operated composing machine to prepare listings in any sequence for duplicator or offset printing. Edge cards can be code-punched in continuous form, then separated, filed and run over and over in any order. The system provides added flexibility for jobs such as records, reference catalogs, library lists and the like which require fast, accurate and economical composition. **Friden Inc., 97 Humboldt St., Rochester 9, N.Y.**

For more details circle #171 on mailing card.

(Continued on page 252)

FUND-RAISING SUCCESS



This new Hammonton, New Jersey hospital is now under construction. Ketchum, Inc. directed the fund-raising campaign.

New Hospital for Hammonton, New Jersey

Community of 20,000 exceeds building fund goal

Hammonton, New Jersey, an industrious community of only 20,000 persons, is building a new hospital. Ketchum, Inc. conducted the preliminary survey and provided full-time professional direction of the fund-raising campaign that exceeded its $500,000 goal by $5,000.

Centered in a fertile, agricultural section, Hammonton has every reason to be proud of surpassing its campaign goal. Today, the construction of the handsome, well-equipped, new Hammonton Hospital is a memorial to the generosity and public spirit of the citizens of the community.

If your hospital is planning a fund-raising campaign in the future, for new construction, renovation or modernization, Ketchum, Inc. will be happy to discuss preliminary plans with you at no obligation. Write to David S. Ketchum, Vice President.

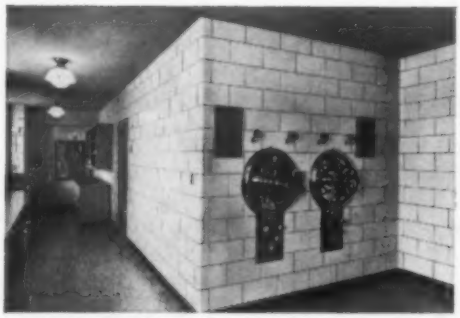
KETCHUM, INC.

Direction of Fund-Raising Campaigns

Pittsburgh 19 • New York 36 • Chicago 3 • Charlotte 2

Charter Member, The American Association of Fund-Raising Counsel

Here's why Natco Vitritile is ideal for hospitals



AUTOCLAVE ROOM in St. Elizabeth's Hospital, Belleville, Ill.



NURSERY in West Virginia Medical Center, Morgantown, W.Va.



CAFETERIA in Children's Hospital, Pittsburgh, Pennsylvania



FRACTURE ROOM in Victory Memorial Hospital, Waukegan, Ill.

Vitritile is sanitary...Vitritile's ceramic glazed facing is non-porous and impervious to moisture. A simple cleansing with common soap or detergent and water is all that's necessary to keep Vitritile sparkling clean and sanitary.

Vitritile is completely fireproof...Vitritile is a genuine, non-combustible clay tile product. Fire resistance ratings of Vitritile have been established by standard fire tests conducted at Ohio State University.

Vitritile is permanently beautiful...Colorful Vitritile never loses its "new look" because its colors and finishes are permanently "fired" on each unit under intense heat. Walls of Vitritile will last the life of any building.

Vitritile is load-bearing...All Natco Vitritile units are designed for use in load-bearing construction in accordance with building code regulations.

Vitritile is chemical resistant...Vitritile meets all chemical resistance tests specified by the Facing Tile Institute.

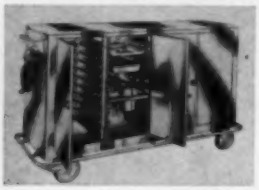
Vitritile is a quality product...All Vitritile units are guaranteed to conform to the quality standards, tolerances and grading rules established by the Facing Tile Institute.

NATCO CORPORATION

General Offices: 327 Fifth Avenue, Pittsburgh 22, Pa. Other Branch Sales Offices: Boston, Chicago, Detroit, Houston, New York, Philadelphia, Pittsburgh, Syracuse, Birminghas, Ala., Brazil, Ind. In Canada: Natco Clay Products Ltd., 57 Bloor St., W., Toronto

Duke Deluxe Conveyor for Hot and Cold Foods

Designed to hold food at proper temperatures and flavor peak while it is being



transported from kitchen to service area, the new deluxe model Duke food conveyor has four compartments. The smaller standard model has two compartments and other sizes are also available, all of stainless steel construction. All compartments may be regulated separately for hot foods, those at room temperature, and with eutectic plates, to keep salads and other cold foods chilled and crisp. **Duke Mfg. Co., 2305 N. Broadway St., St. Louis 6, Mo.**

For more details circle #172 on mailing card.

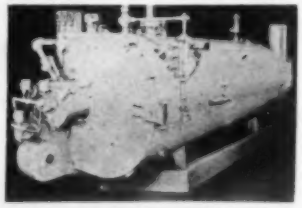
X-Ray Intensifying Screen Has Improved Definition

An entirely new fast tungstate x-ray intensifying screen, offering improved definition, is introduced by Ilford. The screen base is coated with an extraordinarily thin layer of specially prepared fluorescent crystals, which help to produce an image which is unusually sharp, and the surface is covered with a tough protective material which extends the useful life of the screen. The extremely high speed of the screens reduces x-ray exposure significantly. **Ilford, Inc., Ltd., 37 W. 65th St., New York 23.**

For more details circle #173 on mailing card.

Packaged Firetube Boiler Has Unusual Design

Unusual design and outstanding performance are claimed for the new packaged automatic firetube boiler introduced by Orr and Sembower after nearly two years of research and development. The considerably changed appearance of the Powermaster Positive Flow Model PF



shows burner and furnace located on the left side of the horizontal center line of the boiler. It is of three pass design, with no tubes directly above or below the furnace, thus avoiding any impediment to the natural circulation flow. The new design is said to permit boiler feed injection and natural thermal circulation to augment each other, providing maximum water circulating rate and the most efficient form of heat transfer. **Orr & Sembower, Inc., Reading, Pa.**

For more details circle #174 on mailing card.

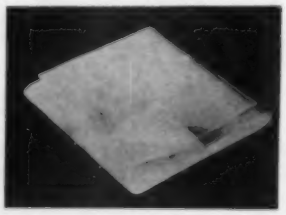
GPL Ultrasonoscope for Accurate Eye Diagnosis

More accurate diagnosis of certain eye ailments is possible with the Ultrasonoscope, a device using ultrasound, which can visualize soft tissues of the eye and reveal conditions not ordinarily detected with other instruments. Ultrasonography is basically a medical use of sonar and radar principles. **General Precision, Inc., 63 Bedford Rd., Pleasantville, N.Y.**

For more details circle #175 on mailing card.

Disposable Blanket Is Waterproof and Durable

Consisting of several plies of white insulating cellulose backed by a soft, tough



polyethylene plastic, the new Busse disposable waterproof blanket is suggested for use in the ambulance, in emergency rooms and where individual use and disposability are factors. The 40 by 72-inch blanket can be used under as well as over the patient. **Busse Hospital Disposables, Inc., 64 E. 8th St., New York 3.**

For more details circle #176 on mailing card.

(Continued on page 254)

NO. 43 IN A SERIES

MISS PHOEBE



"What's the matter, young man—haven't you ever seen an Everest & Jennings *folding* wheel chair?"



Elevating legrest model has 8" casters balance-positioned to compensate for weight of casts.

Happily, since revolving doors aren't among your hospital headaches, you can confine *your* interest in the fingertip fold-ability of Everest & Jennings chairs to such advantages as easy handling and compact storage. Superb balance and maneuverability are additional benefits that both patient and attendant will applaud. And economy-wise administrators never fail to notice that the long, maintenance-free life of Everest & Jennings chairs makes them a bigger bargain every year.

Specify EVEREST & JENNINGS chairs for your hospital

EVEREST & JENNINGS, INC.,
1803 PONTIUS AVE., LOS ANGELES 25, CALIF.



1 Fill the Control Unit; it contains a 3-week supply of water —no refilling during use.



2 Set the Control Unit for the desired temperature—it will be maintained within 1°F.



3 Connect the flow tubes to permit circulation of the water through the K-pad.



4 Apply the K-pad to the required body area (a dampened compress provides moist heat).

How you can save 86% of a nurse's time

Four simple steps, and you've saved as much as 86% of the time required for the nurse to check, refill and replace hot water bottles.

Safe—because the temperature does not vary 1° from the setting prescribed by the physician. The possibility of burn damage is practically nil—a vital consideration where shock, paralysis, or other reason for immobility may be present.

Efficient—the therapy is uninterrupted and unvarying, providing optimum results. It is well tolerated by the patient; whisper-quiet, light, non-restrictive, non-disturbing to skin or dressing. Once set, the unit itself requires no further attention, making the nurse's timesaving available for other patients and ward duties.

Modern—the K-pad is indicated as an effective therapeutic unit in the treatment of phlebitis, arthritis and other inflammations. The control is UL-listed, pads are fully guaranteed and available in several sizes, including a pad for rectal compresses and post-partum uses. • **See your equipment distributor or write us direct. Gorman-Rupp Industries, Inc., Bellville, Ohio.** Distributed nationally by American Hospital Supply Corporation.

2587

THE SAFE, MODERN WAY TO APPLY HEAT OR COLD

aquamatic **K** *pad*

Insecticide Spray in Handy Aerosol Container

Developed especially for use in kitchens and cafeterias to control flies, mosquitoes and gnats, Spix Aerosol is a non-toxic, nonflammable insecticide spray. A valve on the handy container is pressed to release a fine fog, ensuring prolonged and deadly contact with insects. Spix Aerosol is also effective against wasps, roaches and silverfish. **The C. B. Dolge Co., Westport, Conn.**

For more details circle #177 on mailing card.

Genteel Antiseptic For Daily Newborn Baths

Proved effective in reducing bacterial count and skin colonization, new Genteel Baby Bath and Shampoo is mild enough for daily use in infant bathing. Suitable for antiseptic nursery regimens, Genteel is available in gallons or individual plastic units at special prices to hospitals. **Mennen Co., Professional Div., Dept. 2, Morristown, N. J.**

For more details circle #178 on mailing card.





A NEW SYSTEM FOR HANDLING PATIENT TRANSFERS WITHIN YOUR HOSPITAL

★ Lifting is made easy

★ Patients are comfortable at all times during movement

★ Possibility of post-accidental injury is reduced

★ Folding feature permits quick, easy storage in a minimum of space

Stryker PORTABLE WHEEL STRETCHER



No more litter changes . . . No more delays. This versatile new Stryker Stretcher handles your patient transfers in one smooth, efficient operation. Patient and stretcher are lowered onto a portable folding base and remain there, even during examination and X-ray!

Light weight aluminum construction (unit weighs only 29 lbs. complete), locking casters, and corner handles make it easy to move from place to place. Waterproof nylon cover gives comfortable support without pad.

See how easily this new Stryker Stretcher solves your patient handling problems. Ask for one on 30 day trial.



Stryker Orthopedic Frame Company

420 ALCOTT STREET • KALAMAZOO, MICHIGAN

Portable Oxygen Unit Has 51-Minute Supply

Designed for use in emergencies requiring quick application of oxygen, the NCG-Metrox portable oxygen unit supplies 305 liters or 51 minutes of oxygen and is equipped with a regulator which can be adjusted to supply from three to 13 liters per minute. A gauge on each unit shows oxygen pressure in the cylinder. Developed by Metrox, Inc., the device is incorporated into the NCG line of inhalation therapy apparatus. It is a highly dependable unit, well adapted for emergency or daily use in hospitals where lightweight portable oxygen supply with constant flow rate may be needed. Each NCG-Metrox is equipped with a plastic mask which has intake and exhaust valves. **National Cylinder Gas Div., Chemetron Corp., 840 N. Michigan Ave., Chicago 11.**

For more details circle #179 on mailing card.

AIRditioner Line Has Push-button Control

Providing central-system air conditioning with individual room controls, the new Modine line of AIRditioner fan coil units has pushbutton features to save time and effort in service and maintenance. If



neither heating nor cooling is required, air can be circulated merely by operating the blower fans. Quiet operation has been designed into the units, which are available in 11 different types and six colors. **Modine Mfg. Co., 1500 DeKoven Ave., Racine, Wis.**

For more details circle #180 on mailing card.

Up-Right Freezer Features Door Shelves

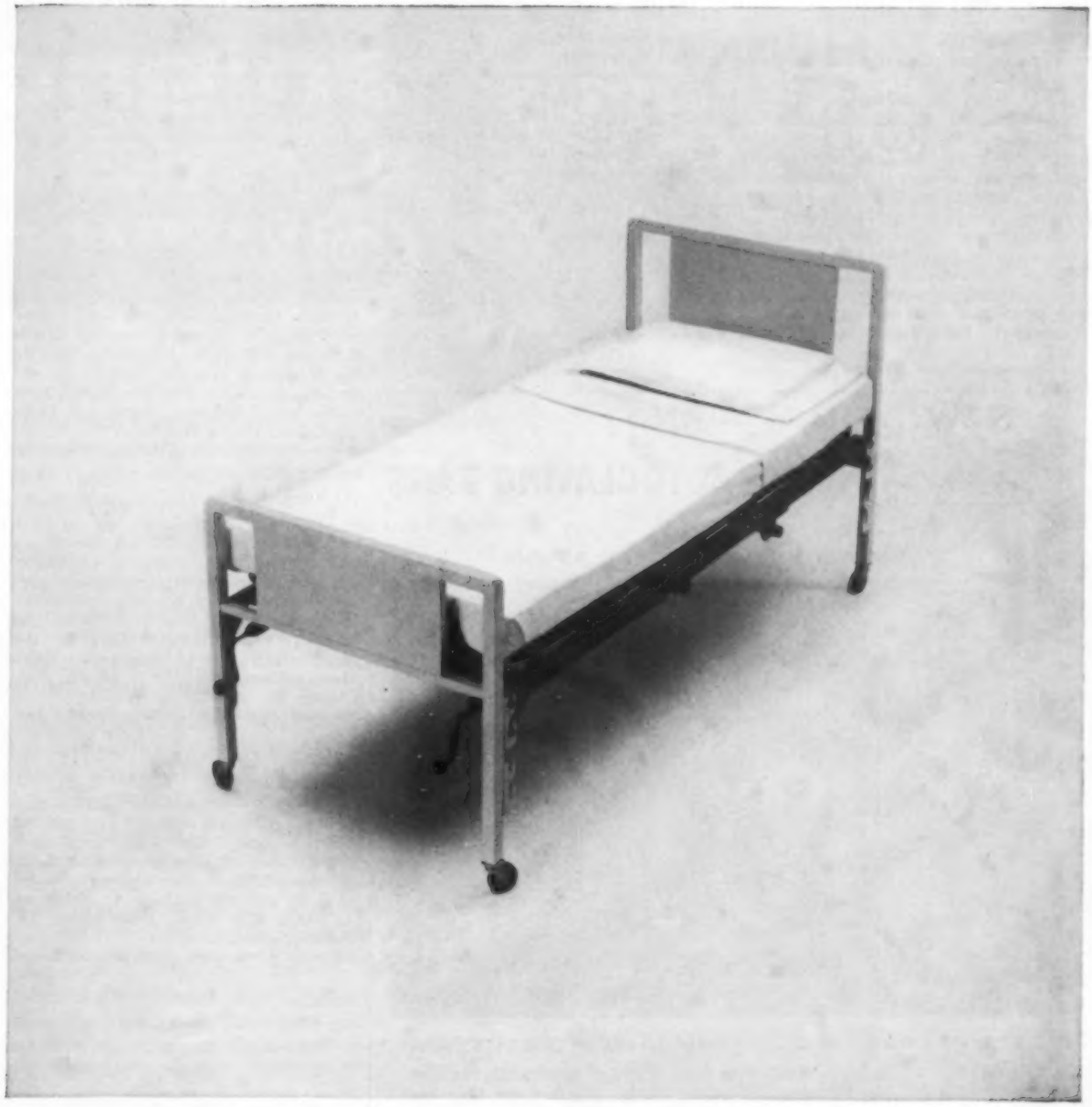
A new self-contained upright freezer, available with manual or automatic defrost, features exclusive door shelves which provide up to 30 percent increase in storage with no increase in overall dimensions. Another exclusive feature is the blower coil, which has a circular design for above average air circulation efficiency. Slides and shelves are interchangeable without the use of tools, and they may be used separately or in combination. **Silver Re-**



frigeration Mfg. Corp., 1469 Utica Ave., Brooklyn 34, N.Y.

For more details circle #181 on mailing card.

(Continued on page 256)



Experts are saying:



"Almost as important as the hospital bed itself..."

The indispensable Kodak X-Omat Processor, Model M4—for 7-minute automatic processing of x-ray film.

Better service to patients. Better service to referring physicians. Better radiographic quality. Smoother work flow—faster reports.

EASTMAN KODAK COMPANY, *X-ray Sales Division*
Rochester 4, N. Y.

See the new Kodak X-Omat Processor, Model M4, at the Kodak exhibit, American Hospital Association meeting, Atlantic City, September 25-28. Models M3 and M4 will be exhibited at the American Roentgen Ray Society meeting, Miami Beach, September 26-29.

Kodak
TRADEMARK

Disposable Irrigating Syringe Has Catheter Tip

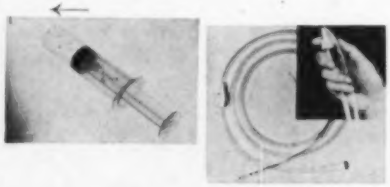
Primarily used for irrigating catheters and intubation tubes in nursing and surgical procedures, the new Stylex Disposable Two-Ounce (50 cc.) Irrigating Syringe with Catheter Tip is of shatterproof polypropylene. It provides safety, convenience and economy since it is disposable after one use, eliminating the possibility of cross infection, is easily stored, and eliminates cleaning, fitting and sterilizing procedures. It can also be used for gastric sampling, inflation of Foley catheters during cystoscopy, irrigating wet dressings, and injecting petrolatum prior to rectal surgery. **Pharmaseal Laboratories, Glendale 1, Calif.**

For more details circle #182 on mailing card.

Klenz-Mate Detergent Now in Disposable Jug

Klenz-Mate liquid dishwashing detergent, chlorinated for protein and stain removal, is now supplied in a disposable plastic gallon jug which permits dispensing directly from the original container. **Klenzade Products, Inc., Beloit, Wis.**

For more details circle #183 on mailing card.



Thermo-Fax Copies Now in Permanent Form

Thermo-Fax Type "A" Pink Systems Paper and Type "B" White Systems Paper combine to make black-on-white permanent reproductions in any Thermo-Fax Copying Machine, at less than two cents per copy. **Minnesota Mining & Mfg. Co., 900 Bush Ave., St. Paul 6, Minn.**

For more details circle #184 on mailing card.

Plastic Shut-off Clamp on Bardic Enema or Harris Tubes

An ingenious plastic shut-off clamp that is easily operated with one hand is now used on Bardic brand enema and Harris flush tubes. Flow is stopped by bringing the tube back over the clamp edge and pushing it into the slot. The flexible connector fits all standard enema cans. **C. R. Bard, Inc., Murray Hill, N.J.**

For more details circle #185 on mailing card.

"Count Calorie" Is Dietetic Ice Milk

Sugar-free "Count Calorie" dietetic ice milk is available in flavor choice of chocolate, vanilla and lemon, in controlled-portioned four-ounce disposable containers. Containing six per cent milk fat and 98 calories, "Count Calorie" has both the taste and texture of ice cream. **Dairy Merchandisers, Inc., 5875 N. Lincoln Ave., Chicago 45.**

For more details circle #186 on mailing card.

Sectional Floor Matting Is Reversible

American Counter Step Matting is a new colored vinyl sectional floor matting which is highly grease-resistant and completely reversible. Designed for use in institutional kitchens, the sections are easy to clean and are available in 13 colors. **American Mat Corp., 1736 Adams St., Toledo 2, Ohio.**

For more details circle #187 on mailing card.

Betadine Swab Aids Are Disposable Applicators

Disposable Antiseptic Applicators for minor wounds, cuts, abrasions and the like



are available in Betadine Swab Aids. Hygienically wrapped individual cellophane tear-off envelopes, 100 to a strip, the swabs are packed in a dispenser box designed for easy wall mounting. Each swab contains Povidone-Iodine ND, the effective germicidal iodine complex that does not sting, stain, sensitize or irritate, and can be safely bandaged. **Tailby-Nason Co., Inc., 350 Fifth Ave., New York 1.**

For more details circle #188 on mailing card.

(Continued on page 258)

NEW...TIME SAVING

Sierra® NYLON AUTOCLAVING BAGS

FOR EASY PACKAGE STERILIZATION



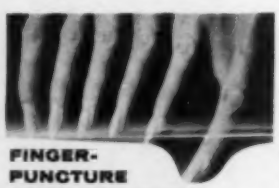
STEAM PERMEABLE/IMPERMEABLE TO BACTERIA

Re-usable Nylon Autoclaving Bags in a wide variety of convenient sizes are now available for safe, easy sterilization and storage of linens, dressings and sharp instruments. Like Sierra's Nylon Autoclavable Film, the transparent bags are 100% impermeable to bacteria, keeping contents sterile till needed. Packaged in units of 100 bags, three sides of the bag come sealed... one end open for loading. May be autoclaved to 287°F. In 12 widths and 10 lengths, ideal for most hospital packaging.

RE-USABLE • DURABLE • TRANSPARENT

NYLON AUTOCLAVABLE FILM ALSO AVAILABLE

All sizes to 25" offered in 100' dispenser-type boxes and 1,000' rolls. May be cut to desired length as needed, with same properties as the Nylon Autoclaving Bags.



FINGER-PUNCTURE STRENGTH TEST

Draw your finger nail across the SIERRA Nylon Film or Bag. Will not puncture or tear. Contents are safe from puncture contamination.

write for descriptive literature

SIERRA ENGINEERING CO.

R. A. HAWKS DIVISION®

123 E. MONTECITO • SIERRA MADRE, CALIFORNIA

engine power
BY CATERPILLAR

YOUR HOSPITAL CAN HAVE THE SAME PROTECTION AGAINST POWER LOSS AS OCHSNER FOUNDATION

Wherever your hospital is, some form of natural disaster—hurricanes, tornados, snow or ice storms—or power line damage may be the cause of utility power interruption. Ochsner Foundation Hospital, New Orleans, lies in the path of frequent hurricanes as they smash across the Gulf of Mexico.

But even during the most devastating storm, Ochsner has power to maintain vital services. When utility power stops, automatic controls start a Caterpillar D397 Diesel Electric Set. In as little as six seconds, electricity again flows into hospital circuits.

Its power can be routed where it's needed most. Operating on a selected load basis, it furnishes 350 KW to various parts of the hospital as needed. It can take over for an hour, a day or months and it's on call around the clock.

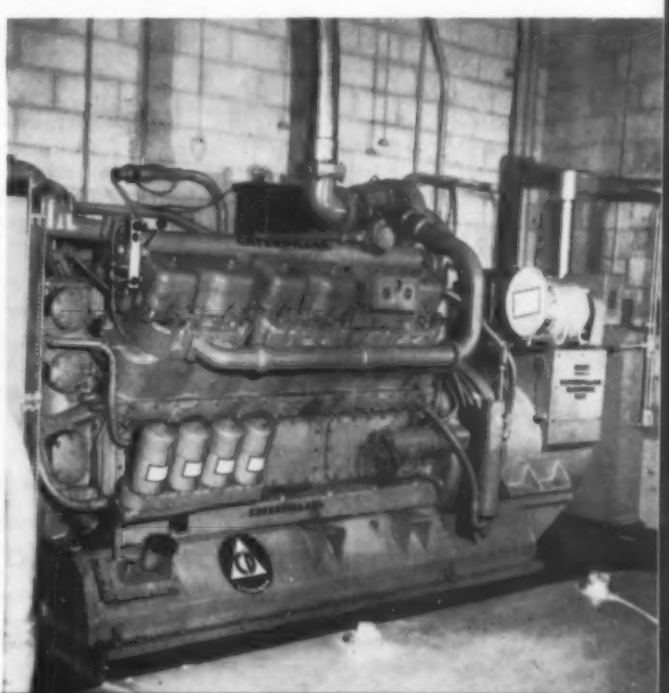
The engine and generator take a full load immediately. And the Cat Diesel Electric Set is inherently safer than a gasoline-powered generator because its fuel is non-explosive—an important patient safety consideration. This also means the possibility of lower insurance rates for you.

But more important even than cost is the reliability of a Caterpillar Standby Set. With lives depending on its performance, your hospital cannot have standby power that's temperamental, needs skilled mechanics to operate it, or that has to have continual adjustments. Caterpillar engine owners regularly report years of constant operation.

There are Caterpillar Electric Sets, diesel or natural gas, for every size hospital. Your Caterpillar Dealer will help you determine the one your hospital needs. He will see that you get the proper engineering and oversee the installation. He will also help you determine if your hospital is qualified to obtain half the cost from the Federal Government under the Civil Defense program. Call your Caterpillar Dealer for the help he can give you. Caterpillar power is dependable power.



This Cat D397 Electric Set furnishes 350 KW on a standby basis to the Ochsner Foundation Hospital, New Orleans. Even though this is a large electric set, note the compact installation.



CATERPILLAR

Caterpillar and Cat are Registered Trademarks of Caterpillar Tractor Co.

Engine Division, Caterpillar Tractor Co., Peoria, Ill., U.S.A.

Oneida Palisade
Is Contemporary Silverplate

Palisade table flatware in silverplate has an asymmetric outline in flowing lines for use with modern decor and tableware. **Oneida Ltd., Oneida, N.Y.**

For more details circle #189 on mailing card.



Line of Cascade Tanks
for X-Ray Film Processing

Fourteen basic tank models and complete accessories for 107 variations to fulfill the processing requirement of every medical x-ray operation make up the new Picker line of stainless steel x-ray film processing tanks. Called Cascade Tanks, they wash film fast and the jet-spray nozzle assures efficient water circulation. Models are available with either single or double thermally insulated compartments, front or back plumbing ready for connection, and with or without backboard, thermal control or water cooler. **Picker X-Ray Corporation, 25 S. Broadway, White Plains, N.Y.**

For more details circle #190 on mailing card.



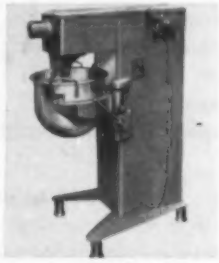
"Magnet Grip" Sweeper
Holds Cleaning Cloths Firmly

The new "Magnet Grip" Sweeper holds cleaning cloths firmly in use, without mechanical fastening. Simple to operate without stooping, the sweeper is placed on a spread cloth and used until it requires a new sweeping surface, then moved down one width, continuing until one side of the cloth is utilized. The cloth can then be turned and the same operation repeated. **Lowndes Products, Inc., 4946 Parkside Ave., Philadelphia 6, Pa.**

For more details circle #191 on mailing card.

All-Purpose Food Mixer
For Heavy Duty Use

Model MF Univex Food Mixer is a combination 22-quart floor model bowl



and beater, constructed for rugged institutional use in kitchen or bake shop, with casters available for mobility if desired. **Universal Industries, 369 Felsway W., Somerville, Mass.**

For more details circle #192 on mailing card.

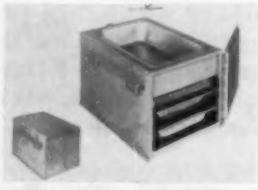
20-Quart Cooker/Mixer
Provides Controlled Temperature

Ideal where controlled temperatures and continuous mixing are required to prevent scorching or sticking, the new 20-quart model TDC/TA-20 Groen Cooker/Mixer is designed for direct steam connection and is made entirely of stainless steel. Twin agitators that mix the contents and scrape the sides of the vessel are powered by a 2-speed, one-half h.p. motor. **Groen Mfg. Co., 1900 Pratt Blvd., Elk Grove Village, Ill.**

For more details circle #193 on mailing card.

Versatile Port-A-Serv
Is Food Transfer Unit

A portable unit that stores and serves a complete menu in standard 2000 series steam table pans, the Port-A-Serv food servicing unit is designed for mass feeding



operations. The lower storage area is individually heated and comes equipped with a combination tray or pan clip. The large capacity serving top area has a seamless hot food well with perimeter heating. **Lincoln Mfg. Co., Inc., 3230 S. Calhoun St., Fort Wayne, Ind.**

For more details circle #194 on mailing card.

(Continued on page 260)

$1.07

A DAY PUTS THIS NEW

ELECTROSECTILIS

IN YOUR HOSPITAL

The new Birtcher ELECTROSECTILIS is the first choice of every surgeon who has tried it. Compact, it takes up less than 2 cubic feet of space; weighs less than 77 pounds; yet has more features and reserve power than any other major electrosurgical unit on the market! With the new Birtcher Medical Equipment Lease Plan you can have an Electrosectilis in every operating and cysto room for just $1.07 per unit...*paid for out of current operating income...with options to purchase* if and when your funds become available.



The compact new Birtcher ELECTROSECTILIS is the first new electrosurgical unit in 15 years ...offers all of the features that general surgeons, urologists and neurosurgeons have asked for ...and more!

☐ Send me details on leasing the new Birtcher ELECTROSECTILIS for only $1.07 a day. Include lease prices on other equipment and sales terms.

☐ Send descriptives on the new Birtcher ELECTROSECTILIS.

Name_____

Address_____

City_____ Zone_____ State_____

THE BIRTCHER CORPORATION DEPT. MH-961

4371 Valley Blvd., Los Angeles 32, California



PLAN A COMPLETE PIPING SYSTEM

From Liquid Supply Units . . .

. . . to Wall Outlets

Building a new wing? Remodeling the old?
Call your Liquid Carbonic representative; let him help you plan a complete piping system for oxygen, nitrous oxide, vacuum, and/or air.

For a helpful data kit, address a request on your letterhead to Department H. You will quickly receive:



- **An illustrated brochure: "The Benefits of Central Supply Hospital Piping Systems"**
- **New specifications: "Hospital Piping Manual"**
- **A handy pipe-sizing slide chart: "Medical Gas Flow Calculator"**

LIQUID CARBONIC
DIVISION OF **GENERAL DYNAMICS**
135 South LaSalle Street, Chicago 3, Illinois
In Canada: Liquid Carbonic Canadian Corporation, Limited, 8375 Mayrand Street, Montreal 9, Quebec

For additional information, use postcard facing back cover.



SAVE STEPS FOR BUSY STAFFERS ...KEEP A STANDBY® NEARBY

An extra Standby Baumanometer® on each patient floor can save much time and effort for busy nursing personnel. These self-contained, easily portable units can be stationed right at bedside when frequent bloodpressure readings are required, as in the care of the post-op patient. This convenient arrangement eliminates hunting and retrieving borrowed instruments.

The Standby Model is particularly well-suited to the demands of hospital service. It is durably constructed for long, hard use; it is easy to read from any position. And it carries the most generous guarantee of any sphygmomanometer available.

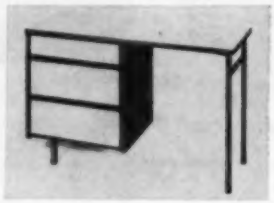
Your local Baumanometer Dealer will be happy to show you the Standby Model...and the entire Baumanometer line designed for practical, economical standardization. Call him.

Baumanometer

W. A. BAUM CO., INC.
Copiague, Long Island, New York

Mark 20 Plastic Top Desk for Nurses' Rooms

Wood-grained plastic is used for the tops and drawer fronts in the new Mark 20 desk, suitable for individual use in nurses' homes. The Hard welded metal frame construction, assuring rigidity and years of trouble-free service, provides a smooth unbroken surface for easy maintenance. The plastic tops and fronts are offered in 13 cheerful colors, blended with wood-grained plastic for homelike appearance. **The Hard Mfg. Co., Box 427, Buffalo 7, N.Y.**



For more details circle #195 on mailing card.

Cottonblossom Thermal Blanket Can Be Boiled and Sterilized

Loomed with an air-cell construction to give greatest insulating properties, the Cottonblossom Thermal Blanket is made of all new cotton fibers. It can be boiled and sterilized without damage or shrinking, is soft and comfortable and produces no static electricity. Maximum warmth is supplied with minimum weight through the new honeycomb weave. The blanket is offered in white, antique white and five pastel colors. **Southern Mills, Inc., 585 Wells St., S.W., Atlanta 3, Ga.**

For more details circle #196 on mailing card. →

Dietetic "Count Calorie" in Controlled Portions

Sugar-free "Count Calorie" dietetic ice milk is now available in four-ounce controlled-portion disposable cups, for patients on low-fat diets. **Dairy Merchandisers, Inc., 5873 N. Lincoln Ave., Chicago 45.**

For more details circle #197 on mailing card.

AL-3 Lowerator For Storage and Dispensing

Constructed of strong, lightweight aluminum, the Model AL-3 Lowerator Dispenser is designed for compact, economical, supplementary storage and dispensing of cups, glasses or trays. The service-level dispensing unit transports equipment from the dishwasher directly to service points without rehandling, thus saving time, labor and breakage. **American Machine and Foundry Co., 261 Madison Ave., New York 16.**



For more details circle #198 on mailing card.

BRONZE PLAQUES

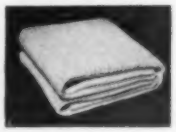
- MEMORIALS
- HONOR ROLLS
- TABLETS
- TESTIMONIALS

Also Plaques of ALUMINUM and NICKEL SILVER

Prompt Estimates—Sketches Furnished

Write for Free Catalog A-84
For Medals and Trophies ask for Catalog B-84

INTERNATIONAL BRONZE TABLET Co. Inc.
150 West 22nd St., New York 11, N. Y.
Tel: WAtkins 4-2323





Kold-Vue Blood Bank Has Safety Alarm System

Offering proper temperature control for blood storage, the Kold-Vue cooler features adjustable, revolving shelves, full vision multi-pane hermetically sealed glass door, and 20-cubic-foot capacity. The automatic safety alarm may be placed at a switchboard or other location for audio and visual alarm if the temperature gets above or below proper units. The cooler is finished in vinyl enamel with rounded exterior corners, and has semi-rigid fiberglass insulation. It may also be used for pharmaceuticals requiring refrigeration. **Kold-Draft Div., Uniflow Co., Erie, Pa.**

For more details circle #199 on mailing card.

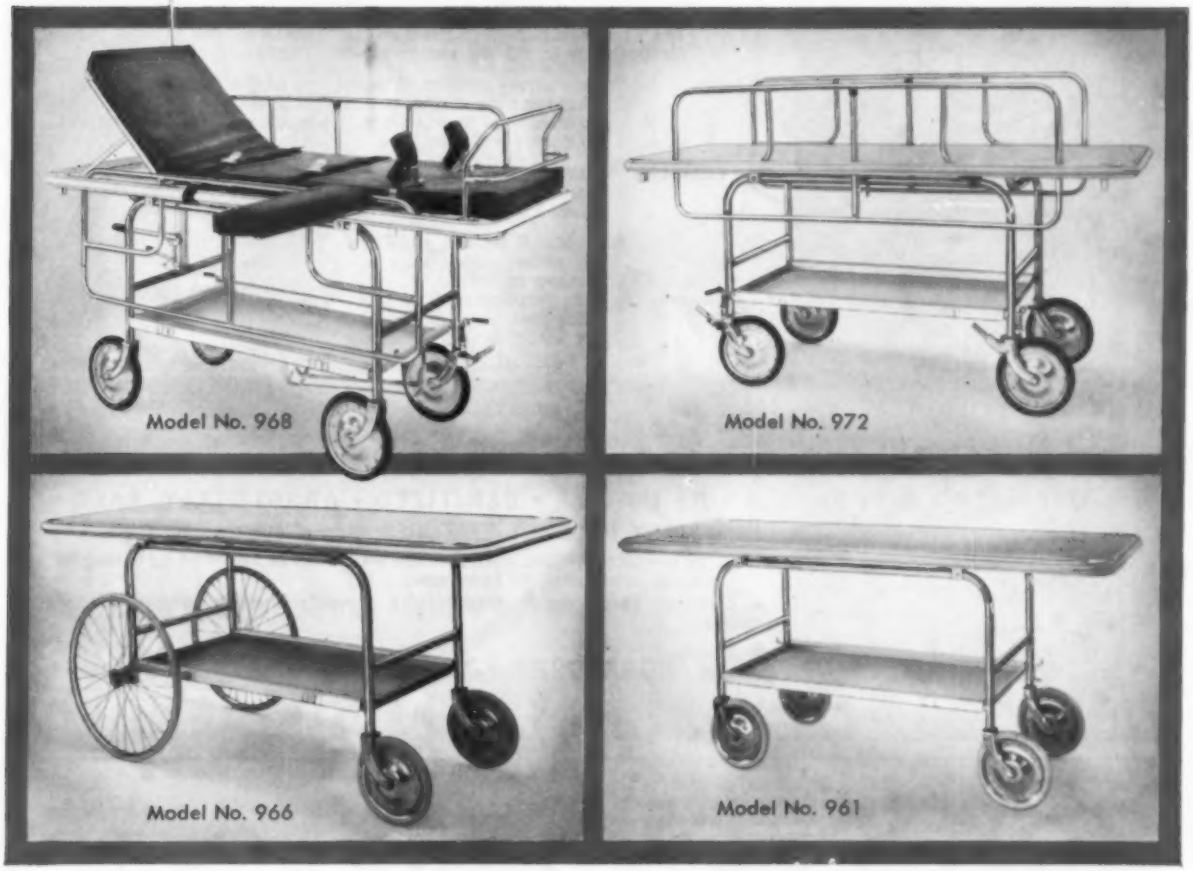
"New Concept" Floor Tile Is Durable, Economical

"New Concept" long wearing, flame-retardant Ruberoid tile has a distinctive binder, Polymerite, developed exclusively by mastic which makes it exceptionally resistant to grease, oil and alkali. Low porosity makes the tile easy to clean and maintain. **The Rubberoid Co., 500 Fifth Ave., New York 17.**

For more details circle #200 on mailing card.

(Continued on page 264)

Finer Equipment at Lower Cost!

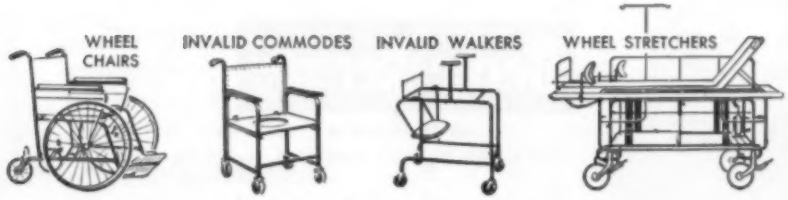


Gendron's Complete Wheel Stretcher Line

Yes, if it's a genuine Gendron, it's the finest of its kind, and at a cost to fit any hospital budget. This all-new Gendron wheel stretcher line has been designed and manufactured with the usual Gendron quality features with ruggedness, ease of handling and patient comfort foremost in mind.

Many features, including Gendron exclusives, such as 1¼ in. Steel Tubing throughout, are standard equipment. However, a complete line of accessories to assure proper patient care are available at a minimum additional cost. Write for Catalog #WS-61, or see your nearest Gendron supply dealer.

GENDRON . . . FOR OVER 85 YEARS THE QUALITY MANUFACTURER OF WHEELED EQUIPMENT FOR THE PATIENT OR THE HANDICAPPED



THE GENDRON WHEEL COMPANY
PERRYSBURG, OHIO

For additional information, use postcard facing back cover.



USES

- Administer Medication
- Aspirate Mucous From Nose
- Pediatric Medication • orally • ears • eyes • nose
- Surgery • eyes • tracheotomy trays, etc.

NEW FLEXIBLE DISPOSABLE DROPPER *CUTS COSTS OVER 50%*

The new Fazio one-piece clinic dropper is making new savings for hospitals in money and time while increasing efficiency.

One survey reports: "The low cost of the TFL Clinic Dropper plus the time saving its use affords made it sensible for us to dispose of them after each use. We saved many hundreds of dollars last year."

COMPARE

* SAVE ON PURCHASE PRICE
Lower purchase price than glass droppers.

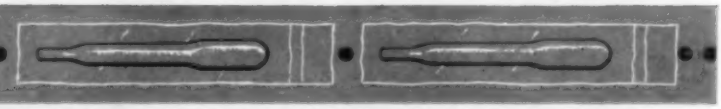
* ELIMINATE MEDICAL HAZARDS
No broken glass injuries to patients and nurses.
No contamination from handling used droppers.
No danger to sensitive membranes.

* CUT HANDLING COSTS
Eliminates: collection, cleaning, sterilizing, storing, redistribution.

* ABSOLUTELY NO BREAKAGE

* SAVE ON STORAGE SPACE

TFL CLINIC DROPPER
OFFICIAL U.S.P. STANDARD



• FLEXIBLE • DISPOSABLE • RE-USABLE • SANITIZED • ABSOLUTELY SAFE •

SEND FOR FREE SAMPLES AND LITERATURE

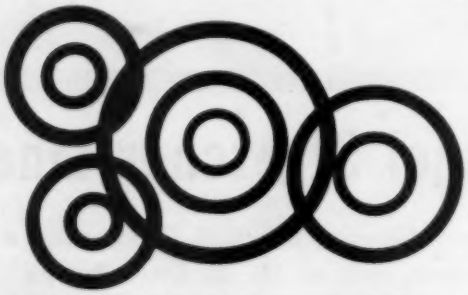
IMPORTANT PRODUCT FEATURES:

Made of one-piece molded vinyl chloride which can be sterilized by boiling for 5 minutes or autoclaving for 10 minutes.

A chemical added during manufacture prevents bacteria penetration and growth.

• THOMAS FAZIO LABORATORIES • Auburn Street, Auburndale 66, Mass. •

Visit us at Booth No. 752, American Hospital Association, Atlantic City, New Jersey, September 25-28th.



JUST AN "O" RING?

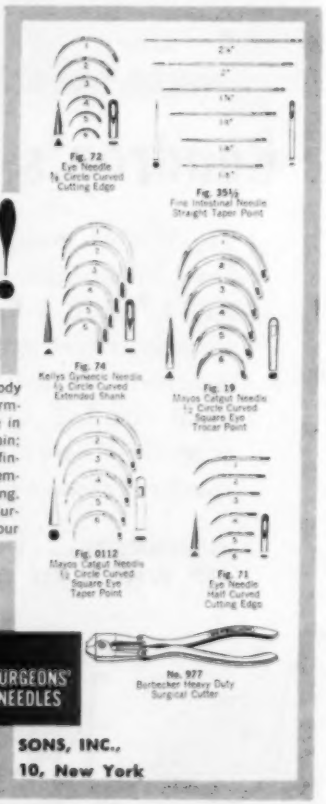
YES, BUT—A GOOD precision "O" Ring can mean the difference between a sure faucet repair job and a continuing problem! You can't get better than GOOD faucet stem, spout and ball cock "O" rings. They're precision made to tolerances in thousandths of an inch—to fit better, last longer, eliminate trouble once and for all.

Use the best. Buy GOOD for the highest quality precision "O" Rings as well as 4,000 other specialties in the GOOD line of plumbing and heating repair parts. Send today for Free GOOD sample assortment and 16-page GOOD Catalog "O".

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SINCE 1896 GOOD HAS MEANT THE BEST.

CORRECT IN THE DETAILS THAT MAKE PERFECTION!



Berbecker Surgeons' Needles embody all the features vital to good performance . . . streamlined eyes for ease in threading, yet sturdy for suturing strain; correctly shaped points with smooth finish; and, entire needle's precision tempered to prevent bending or breaking.

SEND for Berbecker's catalog of Surgeons' Needles or ask for it at your Surgical Supply Dealer.

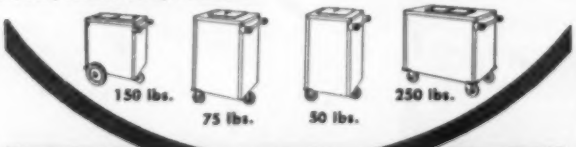
Berbecker SURGEONS' NEEDLES

JULIUS BERBECKER & SONS, INC.
15H E. 26th St., New York 10, New York



ice delivery service direct to the user

No matter where the location, quick, clean, sanitary Ice Service can be had by using GENNETT Model XV all Stainless Steel Ice Cart. Five other models. One will suit your needs. Low in cost. High in quality. Answers your demands for ice service whether standardized routine or irregular service. GENNETT AND SONS INC., One Main Street, Richmond, Indiana.

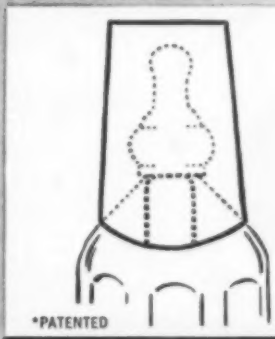


GENNETT Ice Carts

SAFETY IN NUMBERS

It's a wise administrator who has at his fingertips up-to-date information on new developments in equipment and materials which will serve his institution best. Look at the numbers in the yellow sheet in the back of this issue. Each advertiser listed in the index has an identifying number—so does each entry in the "What's New" section. Use these numbers on the yellow postage-paid return cards to request information on products in which you are interested—to be sure the product information you need is in your hands and current.

Remember...



for quick, dependable protection to nursing bottles . . . use the original NipGard* covers. Exclusive patented tab construction fastens cover securely to bottle • For High Pressure (autoclaving) . . . for Low Pressure (flowing steam).

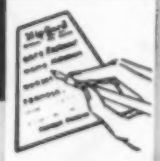
*PATENTED

NipGard TRADEMARK

DISPOSABLE NIPPLE COVERS . . .

provide space for identification and formula data . . . instantly applied to nipple; save nurses time...cover both nipple and bottleneck. Do not jar off. No breakage.

Use No. 2 NipGard for narrow neck bottle . . . use No. H-50 NipGard for wide mouth (Hygeia type) bottle. Be sure to specify type desired.





THE QUICAP COMPANY, Inc.
110 N. Markley St. Dept. MH
Greenville, South Carolina

Your hospital supply dealer has NipGards. Professional samples on request.

REVCO

ULTRA-LOW TEMPERATURE CABINETS



ULTRA-COLD BLOOD STORAGE PROTECTED BY WARMING ALARM

Frozen blood supplies are completely safe—even if power or refrigeration fails—because Revco units have a built-in sound and light alarm to alert staff if warming begins. And, standard 115-230 volt operation means low cost installation.

Full parts, workmanship and service warranty. Most models in stock, modifications on request.

For a FREE copy of the helpful folder, "Selecting a Low Temperature Cabinet," write Revco, Department MH-91.



Industrial Products Div.,
REVCO INC.
Deerfield, Michigan
Setting Trends in Refrigeration Since 1938

Surgipad in Patient-Ready Package Has Sterile "Peelable-Seal"

The J&J Surgipad Combine Dressing is now offered in the sterile, "Peelable-Seal" Patient-Ready Package. Constructed of paper that forms a positive barrier against bacterial contamination, the package cannot be resealed. The "peelable-seal" closure simplifies opening, has a protective lip-seal to prevent the dressing from falling out, and permits removal while observing aseptic technic. Contents of unopened and undamaged packages remain sterile indefinitely, eliminating the need for resterilization. **Johnson & Johnson, Hospital Div., New Brunswick, N.J.**



For more details circle #201 on mailing card.

Improved Product for Keeping Silver Bright

Assure, developed by Economics Laboratory, is now available in improved form. The double-acting product softens crusted food soil while it detarnishes silver and stainless tableware. Its balanced alkalinity neutralizes food acids to prevent pitting and corrosion of stainless steel surfaces and halts corrosion already present. Tableware is kept bright and sparkling when Assure is used regularly. **Economics Laboratory, Inc., 250 Park Ave., New York 17.**

For more details circle #202 on mailing card.

American Vacuum Kit Simplifies Boiler Cleaning

A handy kit, consisting of a paw tool for vacuum cleaning soot and scale from flat surfaces in fire box, boiler tube expansion scraper cones, wire brush, and steel crevice tool, simplifies boiler cleaning so that it is easily handled without



spreading soot or dirt. **American-Lincoln Corp., 518 S. St. Clair St., Toledo 3, Ohio.**

For more details circle #203 on mailing card.

Two Weight Control Foods Introduced by Pet Milk

Two new weight control dietary food products are introduced by Pet Milk, Sego Liquid Diet Food packed in cans, which does not require refrigeration, and Pet Diet Food 900, a fresh dairy product. Each Sego 10-ounce can provides a complete meal substitute containing 225 calories. Pet Diet Food 900 is available in quart milk cartons, and fulfills the same daily diet requirements as four servings of Sego. **Pet Milk Co., 1401 Arcade Bldg., St. Louis 1, Mo.**

For more details circle #204 on mailing card.

Cooling-Heating Units For Single Level Buildings

A combined heating and cooling unit and a completely self-contained roof-top cooling unit are introduced for single level institutions and commercial buildings. The cooling system is supplied as a separate unit, while the year-round temperature control system is a three-part package, consisting of an air cooled condenser unit, a cooling section and a gas-fired unit for heating. **Curtis Mfg. Co., 1956 Kienlen Ave., St. Louis 33, Mo.**

For more details circle #205 on mailing card.

Special Lumar Fabric Softener Leaves Bacteriostatic Finish

Augmenting the benefits of regular powdered Lumar fabric softener, Special Lumar leaves a bacteriostatic finish on linens that is effective even against antibiotic-resistant staph. Protection is residual and will remain active under normal condition. **Marlyn Chemical Co., Inc., Lakeview, Ohio.**

For more details circle #206 on mailing card.

(Continued on page 266)



A WORLD OF BAKING IDEAS

Special Day!
HOTEL INSTITUTION IN-PLANT FEEDING DAY
Thursday, Oct. 12th

FOR EVERY INSTITUTIONS' EXECUTIVE RESPONSIBLE FOR MASS FEEDING!

1961 BAKING INDUSTRY EXPOSITION

PAGENT OF PROGRESS

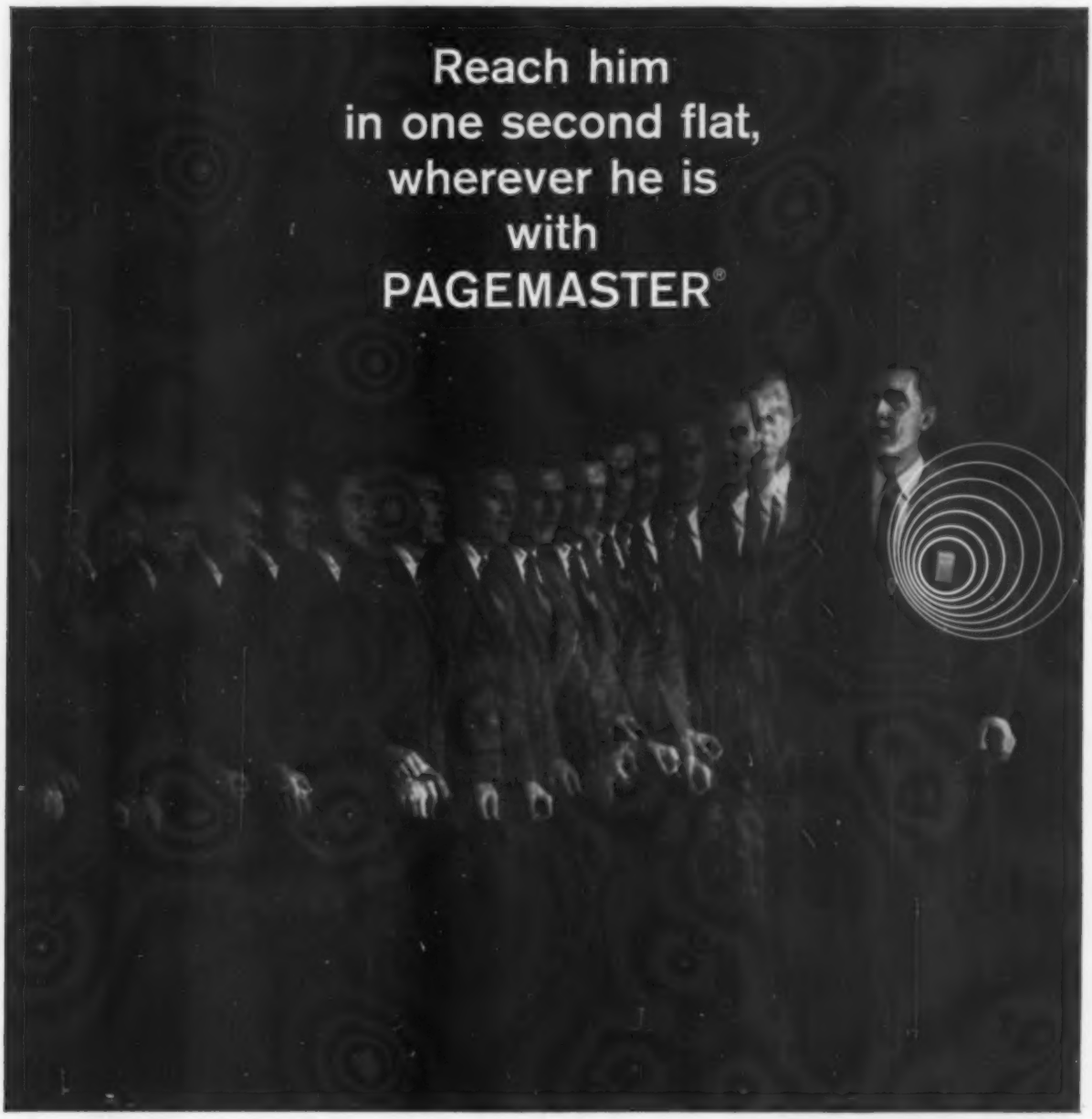
OCTOBER 7th thru 12th • CONVENTION HALL • ATLANTIC CITY

This is the show for you, Mr. Institution's Executive! 953 exhibits . . . 303 exhibitors . . . watch advanced baking techniques demonstrated . . . social events, too . . . planned for your education, inspiration and enjoyment. An endless array of new ideas, machinery, equipment, services and innovations . . . the very latest in the world of baking will be on display for your benefit. See you in Atlantic City!

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Make your reservations today . . . for further information write
AMERICAN BAKERS ASSOCIATION, 20 N. Wacker Drive, Chicago 6, Ill.

Reach him in one second flat, wherever he is with PAGEMASTER®



Locate him instantly—in the lab, in the wards, in another wing, even out of doors—way beyond the range of conventional paging systems.

Alert him—and only him. His—and only his—pocket-sized PAGEMASTER will beep discreetly. And will sound, again and again until he checks in. For PAGEMASTER is gentle but insistent.

What equipment do you need for a PAGEMASTER Selective Wireless Paging System? Nothing more than a desk-top encoder, a transmitter, an antenna, and transistorized, feather-weight receivers. Installation is immediate and inexpensive—no costly lights, loops or speakers are needed, no expensive drawn-out structural modifications are involved. And you can add receivers—up to several hundred—as your paging applications increase.

Want to see how much faster and how much more economically PAGEMASTER reaches key people . . . to help them get things done? Your STROMBERG-CARLSON® Communications Consultant has the irrefutable facts. For his name, call Western Union Operator 25, or write:

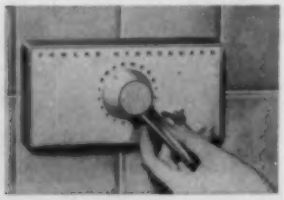
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GENERAL DYNAMICS | ELECTRONICS

In modern hospital communications . . . THERE IS NOTHING FINER THAN A STROMBERG-CARLSON®

Hydroguard Shower Control Has Redesigned Handle

Restyled in a satin chrome case with an easy-grip pointer handle for simple,



single-hand operation, the Powers Hydroguard Thermostatic Shower Control prevents scalding water even if the handle is turned to maximum hot position, and also prevents sudden bursts of hot or cold water. **Powers Regulator Co., 3400 Oakton St., Skokie, Ill.**

For more details circle #207 on mailing card.

Practice Set of Forms For Instruction in Accounting

Designed for use with the textbook, "Principles of Hospital Accounting," by Prof. L. Vann Seawell, D.B.A., C.P.A, a new set of practice accounting forms is offered for instruction in hospital accounting methods. Consisting of 60 typical forms, the Practice Set enables the beginner to learn and apply all accounting steps described in the text. **Physicians' Record Co., 3000 S. Ridgeland Ave., Berwyn, Ill.**

For more details circle #208 on mailing card.

Cater Supreme Trays Designed for Durability

Designed specifically for resistance to strong acids and for superior strength retention, Cater Supreme trays are made of a new bisphenol polyester resin, fiberglass reinforced, and may be autoclaved. Colors go completely through the tray and are guaranteed not to bleach out, chip off or separate in any way. **Houston Reinforced Plastics Co., Inc., 3215 W. Alabama, Houston 27, Tex.**

For more details circle #209 on mailing card.

Fire Alarm Station Is Positive and Foolproof



The new Flexalarm Century Non-code single-action Fire Alarm Station is shock and vibration resistant and fills the need for a small emergency signalling station which is positive and foolproof. Pulling the bullseye alarm lever forward transmits the alarm and locks the signal in "out" position until reset by an authorized person. **Gamewall Co., 1239 Chestnut St., Newton Upper Falls 64, Mass.**

For more details circle #210 on mailing card.

Modular Components in Markette Steam Cooker

Compartment Cookers, Steam-Its, 10 and 20-quart tilting kettles and 30 and 40-gallon stationary or tilting kettles can now be combined to meet kitchen requirements with the new modular components in the Markette Steam Cooker line. **The Market Forge Co., Everett 49, Mass.**

For more details circle #211 on mailing card.

Model 55 Hemophotometer for Direct-Reading

Direct-reading of hemoglobin concentration in grams of hemoglobin per 100 ml of blood is possible with the New Model 55 Hemophotometer. The direct-reading



colorimeter is easy and quick to use, and precision is attained by eliminating the rarely-encountered extreme values and expanding the scale. When the cuvet containing a prepared blood sample is pushed down into the sample well, it trips a microswitch that turns on the power for immediate reading. **Fisher Scientific Co., 373 Fisher Bldg., Pittsburgh 19, Pa.**

For more details circle #212 on mailing card.

(Continued on page 268)



how to cut maintenance costs *with* new decor ideas!



Our Hospital Planning Guide Book shows you, step-by-step, through planning and installation, how Vicrtex gives your wallcovering and maintenance budget "Tender-Loving-Care." Colorful brochure tells you everything you need to know — the style, fabric and color combinations and the wide selection of unique coverings . . . for every wall . . . in every room.

Upkeep costs disappear with the functional beauty of Vicrtex; it takes the grinds, thumps and bumps without a sign of wear . . . won't crack, peel, fade, snag or scratch — ever!

The Vicrtex VEF HOSPITAL PLANNING GUIDE BOOK is your answer for new ideas, factual data, tested applications and installations.

All Vicrtex Fabrics U/L approved

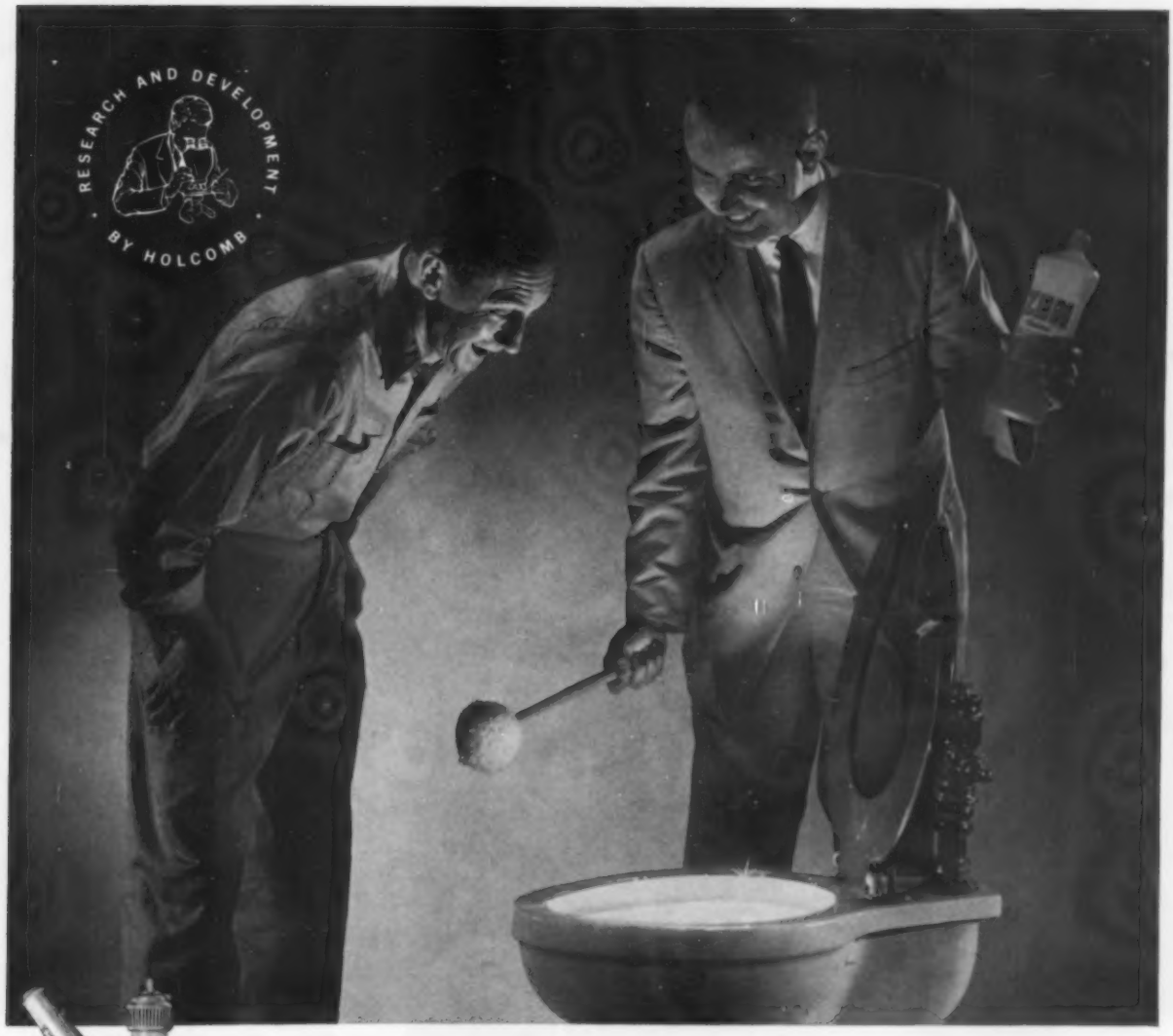
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Empire State Building, New York 1, LOngacre 4-0080 • Mills: Wharton, N. J.

In Canada: **Shawinigan Chemicals Ltd., Canadian Resins Div., Montreal, Que. & Weston, Ont.**

VICRTEX V.E.F. vinyl wallcovering





ZEN comes in unbreakable "Sure Grip" Polyethylene bottles. FREE acid-resistant Acrilan swabs and waste-eliminating "Pour-A-Caps" with each case.

MODERN MAINTENANCE FACT:

Holcomb ZEN makes vitreous sparkle

Keeping toilets and urinals really clean is vitally important for good employee (and customer) relations.

Swabbed on vitreous ware, ZEN cuts through hard-to-remove stains and discolorations, yet does not attack vitreous or corrode plumbing. In a matter of seconds, fixtures come *clean*, *sanitized*, *odor-free* and *sparkling*—all in one easy operation.

Every cleaning job, from the most difficult to the most insignificant, can be done better and faster with Holcomb products, scientifically designed to save time and money. *Ask your nearby Holcombman.*

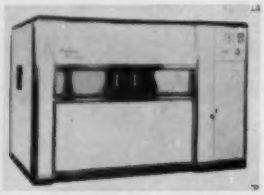
J. I. HOLCOMB MANUFACTURING CO., INC.

INDIANAPOLIS 7, INDIANA

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Middleby-Marshall Oven Has Modulating Heat Control

The 1961 model of the Middleby-Marshall Heavy Duty Revolving Tray Oven



features modulating heat control plus dual vent, electronic controls and inner walls of aluminized steel. **Middleby-Marshall Oven Co., 739 W. Adams St., Chicago 6.**

For more details circle #213 on mailing card.

Disposable Culture Tubes Are Low Cost and Durable

Recommended for tissue culture, clinical and biological testing, the new low-cost, disposable Corning Culture tubes of borosilicate glass are chemically durable and resistant to thermal shock. **Corning Glass Works, Corning, N.Y.**

For more details circle #214 on mailing card.

Liquid Dust Mop Treatment Is Bacteriostatic

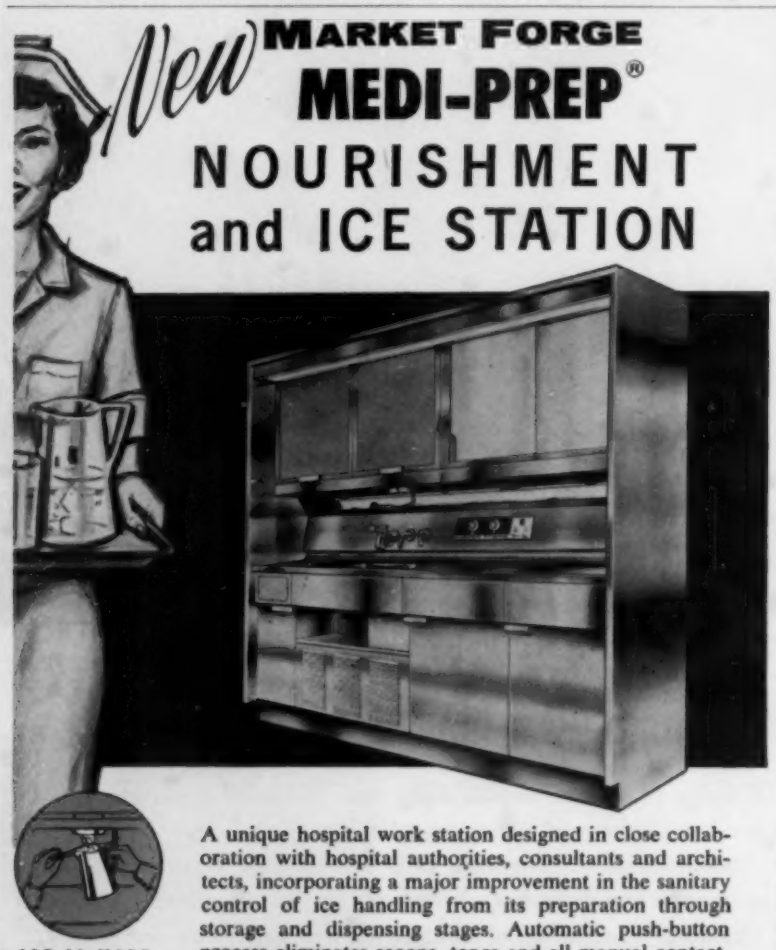
Primarily developed to meet the rising need for control of dangerous dustborne pathogenic bacteria and virus organisms which contaminate populated rooms, Remel-1910 is a bacteriostatic liquid emulsion sweeping compound for treating dust mops and dust cloths. It attracts and absorbs dust like a magnet, converting it into heavy lint which shakes out easily. The cleaning agent is safe for use on all floors and dusting areas, and is concentrated for economy and easy storage. **Conco Chemical Co., 2411 Swiss Ave., Dallas 21, Tex.**

For more details circle #215 on mailing card.

Fire Detection Thermostat Is Super-Sensitive and Fast

Thermotech Model 302, a new, supersensitive, trouble-free fire detection thermostat, approved by Underwriters laboratories, promptly actuates alarms in hospitals, schools and other institutions. Hermetically sealed, explosion-proof and corrosion-resistant, Thermotech can endure chemical and acid fumes, dust, moisture and sub-zero temperatures. It may be used on 40 by 40 foot spacing. **Tomorrow, Inc., 7 W. Jackson, Hayward, Calif.**

For more details circle #216 on mailing card.



ICE IS MADE, STORED, AND AUTOMATICALLY DISPENSED DIRECTLY INTO CONTAINER. NO SCOOPS OR HANDLING.

A unique hospital work station designed in close collaboration with hospital authorities, consultants and architects, incorporating a major improvement in the sanitary control of ice handling from its preparation through storage and dispensing stages. Automatic push-button process eliminates scoops, tongs and all manual contact. A compact, self-contained, specialized unit with complete facilities for ice service plus refrigerator, work counter and cabinets with cooking units and all accessories necessary for the preparation, storage and service of prescribed nourishment and supplementary between meal diets. Fluorescent lighting—stainless steel construction. Detailed brochure on request. Write dept. MH-9.

FROM THE ORIGINATORS OF THE FIRST STANDARD HOSPITAL WORK STATION, THE WIDELY-USED ONE-STOP MEDI-PREP MEDICINE STATION . . .

MF

MARKET FORGE CO.

EVERETT 49. MASS.

Pharmaceuticals

Cosa-Terrastatin

An addition to the Terramycin line of antibiotics is introduced by Pfizer in Cosa-Terrastatin Capsules and Oral Suspension. Cosa-Terrastatin is a therapeutic formulation containing Terramycin for broad-spectrum antibiotic therapy, nystatin, an antifungal antibiotic, for added protection against possible monilial superinfection, and glucosamine hydrochloride, a natural substance for substantially increased absorption of Terramycin. **Chas. Pfizer & Co., Inc., 800 Second Ave., New York 17.**

For more details circle #217 on mailing card.

Coly-Mycin Injectable

A new antibiotic for severe acute and chronic resistant urinary tract infection due to strains of gram-negative organisms, Coly-Mycin is also indicated in other serious gram-negative infections involving the respiratory tract, surgery, wounds, burns and blood poisoning. It is particularly indicated when infections are caused by Pseudomonas aeruginosa, an organism commonly resistant to most antibiotics, and is also effective against Escherichia coli, Aerobacter aerogenes, Klebsiella pneumoniae and Brucella. It is available for intramuscular injection in 150 mg. vials. **Warner-Chilcott Laboratories, Morris Plains, N.J.**

For more details circle #218 on mailing card.

Mylaxen

Mylaxen is described as a new safety factor in surgical relaxation for use in anesthesiology. It is a selective plasma cholinesterase inhibitor. When used together with small doses of the muscle relaxant succinylcholine, an evenly sustained surgical plane of muscular relaxation is provided, with minimum risk of untoward effects. Mylaxen is a bisquaternary ammonium compounds, hexafluorenium bromide, and is supplied in 10 cc. multiple-dose vials. **Irwin, Neisler & Co., Decatur, Ill.**

For more details circle #219 on mailing card.

(Continued on page 270)

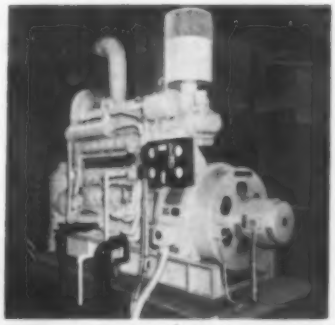


Fairbanks-Morse O-P Diesels keep emergency lines open!

When commercial electric power is suddenly cut off, emergency generating equipment becomes the most important single investment ever made by an institution or business.

With the F-M 38F5¼ Opposed-Piston Diesel Generating Unit, only 15 seconds lapse between loss of commercial power and new, F-M generated power . . . 15 seconds for the 38F5¼ to come to full power *from a cold start.*

Experience has taught telephone companies to use F-M Diesel Generating Equipment to handle emergencies. It goes to work instantly maintaining automatic dialing and toll lines. Hospitals, institutions, factories, hotels and schools also need this vital protection. And F-M diesels are backed up by the reputation of the leader in the field. **For full details on Model 38F5¼, or any other manually or automatically controlled unit, write: S. K. Howard; Director of Marketing; Beloit Division; Fairbanks, Morse & Co.; Beloit, Wisconsin.**



MODEL 38F5¼ OPPOSED-PISTON DIESEL GENERATING UNIT
Delivers more kw at less cost, in less time . . . in less space than any other unit. Opposed-Piston design minimizes vibration, produces fine balance . . . smooth power and instant response. 40% fewer moving parts than comparable engines of equal horsepower mean reduced maintenance . . . fuel and lube oil savings. Range from 170-616 kw.

FAIRBANKS MORSE
A MAJOR INDUSTRIAL COMPONENT OF
FAIRBANKS WHITNEY

Velban

A new agent for the treatment of generalized Hodgkin's disease and choriocarcinoma refractory to other therapy, Velban is the sulfate salt of vinblastine, an alkaloid of the periwinkle. It is supplied in 10 mg. 10 cc. rubber-stoppered (dry powder) ampules. **Eli Lilly & Co., 740 S. Alabama St., Indianapolis 6, Ind.**

For more details circle #220 on mailing card.

Perithiazide SA

A new drug for coronary artery disease complicated by heart failure and/or high blood pressure is offered in Perithiazide SA. Each sustained-action tablet contains Peritrate, an exceptionally safe, long-acting vasodilator, and hydrochlorothiazide, an effective diuretic, and represents a single-tablet approach to provide both prompt and prolonged relief. **Warner-Chilcott Laboratories, 201 Tabor Rd., Morris Plains, N.J.**

For more details circle #221 on mailing card.

Entoquel

Thihexinol is a new, pharmacologically specific, non-narcotic antiperistaltic agent for the symptomatic treatment of diarrhea in children. It is said to act almost exclusively to inhibit gastrointestinal motor function and does not interfere with gastric secretion or digestive processes, or produce other undesirable effects. Marketed as Entoquel, it is supplied in two syrup forms, one with thihexinol alone, for nonspecific diarrhea, and one with Neomycin, for combating enteric organisms responsible for bacterial diarrhea. **White Laboratories, Kenilworth, N.J.**

For more details circle #222 on mailing card.

meeting a widespread professional demand

BARD-PARKER DISINFECTING SOLUTIONS

B-P HALIMIDE

Concentrate Disinfectant

. . . now *improved*. HALIMIDE disinfectant—**free from objectionable odor,** is a concentrate of low surface tension and excellent penetrating qualities. Perfect for inexpensive instrument disinfection, 1 oz. mixed with 1 gal. of water makes a stable—clear—non-corrosive—non-staining solution. TUBERCULOCIDAL when diluted with alcohol. No anti-rust tablets to add—no need for frequent changing.





B-P CHLOROPHENYL Disinfectant

. . . an ideal instrument disinfecting solution for professional office use. It is **rapid** in destruction of commonly encountered vegetative bacteria—free from phenol (carbolic acid) and mercurials—not injurious to skin or tissue. It is used full strength—has a pleasant odor—its germicidal efficiency is not affected by soap.



B-P FORMALDEHYDE GERMICIDE

. . . **sporicidal • tuberculocidal • bactericidal • virucidal • fungicidal,** it is especially suitable for hospital use in the chemical disinfection of instruments and protection of surgical sharps. It is used full strength—and within 5 minutes will kill TUBERCLE BACILLI—vegetative pathogens and spore formers—the spores themselves within 3 hours.

B-P **BARD-PARKER COMPANY, INC.**
DANBURY, CONNECTICUT
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Alphosyl Lubricating Cream

Alphosyl Lubricating Cream is a new form of Alphosyl containing allantoin and special coal tar extract, formulated in a cream base consisting of a combination of saturated and unsaturated free fatty acids, naturally occurring triglycerides, sterols and esters resembling the lipoid constituents of normal healthy skin, for topical therapy of psoriasis, especially in intertriginous areas. It is also indicated in resistant psoriasis where other preparations have failed. **Reed & Carnrick, Kenilworth, N.J.**

For more details circle #223 on mailing card.

Miluretic

Miluretic is a diuretic-antihypertensive and tranquilizer preparation. Each tablet contains 25 mg. of the diuretic, hydrochlorothiazide, and 200 mg. of Miltown. The combination is recommended for the treatment of hypertension, all types and grades of severity of congestive heart failure, and premenstrual tension, especially when anxiety and tension are complicating factors. **Wallace Laboratories, Cranbury, N.J.**

For more details circle #224 on mailing card.

Emivan

A respiratory stimulant, Emivan has been rigorously tested in hospital emergency wards for two years. It is indicated to revive persons in coma from overdosage of barbiturates, other sedatives and hypnotics, narcotics and many depressant chemicals. It is administered both by intravenous injection and by mouth and in clinical tests has been employed successfully to lighten surgical anesthesia as well as to treat emergency cases. **U.S. Vitamin & Pharmaceutical Corp., 250 E. 43rd St., New York 17.**

For more details circle #225 on mailing card.

Isordil With Phenobarbital

A new preparation for the treatment of angina pectoris and coronary insufficiency, Isordil with Phenobarbital is a potent long-acting coronary vasodilator with a prompt onset. It is highly effective with patients whose anxiety and emotional disturbances complicate their condition. Exercise tolerance is increased and attacks decreased, giving the patient a new feeling of well-being. **Ives-Cameron Co., 685 Third Ave., New York 17.**

For more details circle #226 on mailing card.

Biphetamine-T

Useful in providing sustained weight control in obese patients who are refractory to existing methods of treatment, Biphetamine-T contains Tuazole, thus sustaining weight loss for longer time periods. The single capsule dose gives appetite appeasement with mild invigoration and calmative action for ten to 14 hours. **Strasenburgh Laboratories, 755 Jefferson Rd., Rochester 3, N.Y.**

For more details circle #227 on mailing card.

(Continued on page 272)

comparison proves

Nutting FOOD-ala-CART®



SERVES YOU BETTER
SAVES YOU MONEY

Compare QUALITY

and you will find Food-ala-Cart uses only the best materials inside and out. This extra quality means extra years of fine service.

Compare FEATURES

and you will find Nutting gives you more practical design features for easier, faster food service.

Compare PRICES

and you will discover that dollar for dollar, feature for feature, you get more for your money with Food-ala-Cart.

Here's how Nutting Food-ala-Cart will serve your hospital better

- Exclusive Food-ala-Cart design makes tray preparation, assembly and tray serving easier.
- Every drawer in left oven column matches a patient tray in left cold column. The same is true with the right column of oven and tray sections.
- Food-ala-Cart helps maintain **balanced nutrition** with 3 separate and distinct sections to keep **hot foods hot, cold foods cold** and **frozen foods frozen.**
- 6 drawer freezer section holds at 0°F.
- Each Food-ala-Cart is equipped with two 7-quart thermo jugs that keep hot or cold drinks at proper temperature up to 3 hours from filling time.
- Food-ala-Cart is available in 5 models for serving from 16 to 24 patients.
- Food-ala-Cart has large unobstructed tray assembly area with end guard rails.
- Full length top shelf permits locating thermo jugs for easiest service.
- Large wheels with replaceable, easy rolling tires have lifetime lubricated, shielded wheel bearings. No greasing is ever required.
- Eye level control panel is easily seen and well protected.
- Clean up time with Food-ala-Cart streamlined design is 25% faster because everything in the interior is quickly and easily removed and replaced.
- Food-ala-Cart offers nationwide service and distribution.
- Listed under re-examination service of Underwriters Laboratories, Inc.

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Fig. 1989 Mobile Ice Chest


Fig. 1919-ST Shelf Truck


Fig. 987 Refuse Can Truck


1154-GR Glass Rack & Milk Case Dolly


Fig. 882 Linen and Laundry Truck


Fig. 845 Platform Truck


Fig. 883-LW Round Container Dolly


Fig. 1152 Two Wheel Truck

On display, Booth 600, American Dietetic Assn. Annual Meeting, Oct. 24-26, St. Louis, Mo.

Literature and Services

• **Seventy-nine ideas to reduce cleaning maintenance costs** are described in a handbook prepared by Breuer Electric Mfg. Co., 5100 N. Ravenswood Ave., Chicago 40. New ideas, improved methods for handling tedious jobs more easily and economically, and how to rate the efficiency of cleaning methods are discussed in the booklet, which features the Tornado Series 400 industrial vacuum.
For more details circle #228 on mailing card.

• A new **36-page catalog** of the products of Beam Metal Specialties, Inc., 25-11 49th St., Long Island City 3, N.Y., is now available. A new binding allows the catalog to be readily identified, and individual sections by product identification are available. The catalog includes data on new products, chart racks for desk and wall hanging, wheeled chart carriers and BMI cards.
For more details circle #229 on mailing card.

• A series of catalogs on its **architectural products** is available from The R. C. Mahon Co., P.O. Box 4666, Detroit 34, Mich. Products described and illustrated include steel deck, structural Cel-beam sections, insulated curtain walls and fire walls and rolling steel doors. Property and load tables are given in the deck and floor catalogs, with new load tables in the curtain wall catalog.
For more details circle #230 on mailing card.

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PRO-TEX-MOR

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• **"Carpets for Every Public Space"** are described in a colorful booklet on Lees Commercial Carpets available from James Lees and Sons Co., Bridgeport, Pa. Subjects such as "Why to Carpet," "Where to Carpet" and "How to Carpet" are discussed, and carpeting of areas in schools, hospitals, offices, theaters and other institutions is described in words and illustrations. Stock commercial carpeting is described and "Points to Remember in Planning for Carpet" are outlined.
For more details circle #231 on mailing card.

• The **Epsco Surgical Master Monitor**, an integrated electronic system for gathering, recording and displaying data on patient condition during and after surgery, is described in a six-page brochure offered by Epsco, Inc., 275 Massachusetts Ave., Cambridge 39, Mass.
For more details circle #232 on mailing card.

• The complete line of **Bucksco Temper-Lumium Mobile Service Equipment** for hospitals and other institutions is described in a new catalog released by Bucks County Enterprises, Inc., Quakertown, Pa. Each product page faces a comparable specification page with detailed dimensional sketches, and a picture index on the inside front cover facilitates use of the catalog.
For more details circle #233 on mailing card.

• A series of **posters in Spanish, covering common maintenance situations,** is offered by the National Sanitary Supply Assn., 159 N. Dearborn St., Chicago 1, to help in teaching Spanish speaking custodians how to do their jobs effectively.
For more details circle #234 on mailing card.

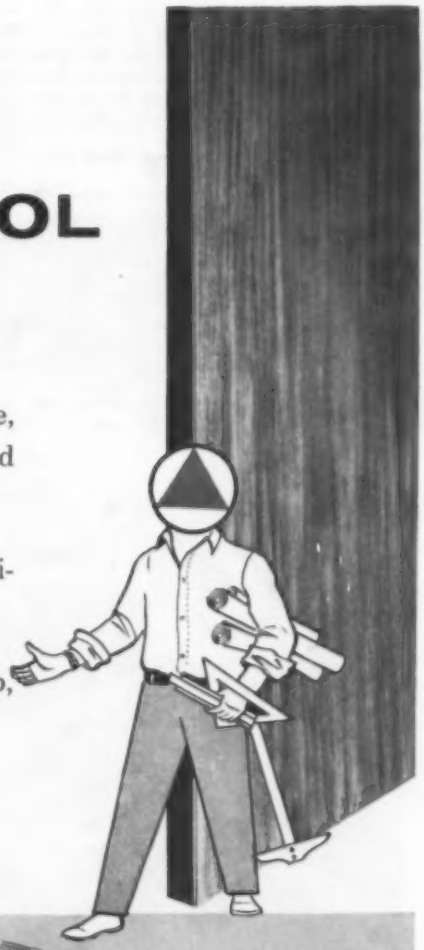
• **Prefabricated Toplite Roof Panels,** the skylight that controls brightness and solar heat, are the subject of an eight-page catalog published by Products Research Co., 2919 Empire Ave., Burbank, Calif. Design data on the Toplite unit, orientation and illumination information, as well as construction details and other technical facts are included in the illustrated booklet.
For more details circle #235 on mailing card.

• **"New Techniques of Bandaging With Tubegauz"** is the title of a manual on the use and application of the improved seamless tubular gauze bandage and the new cage-type applicators. Prepared by The Scholl Mfg. Co., Inc., 213 W. Schiller St., Chicago 10, manufacturer of the versatile and efficient bandaging product known as Tubegauz, the booklet is written in text form and illustrates each procedure described.
For more details circle #236 on mailing card.

• **Nethcraft Comfort Accessories,** including the new Deluxe Comfortaire inflatable cushion with double electronically welded seams for longer life, are described in a new catalog offered by The Art Neth Company, 400 Deming Place, Chicago 14. The complete line of material, light, durable and easy to handle, yet giving complete patient comfort, is included.
For more details circle #237 on mailing card.
(Continued on page 274)

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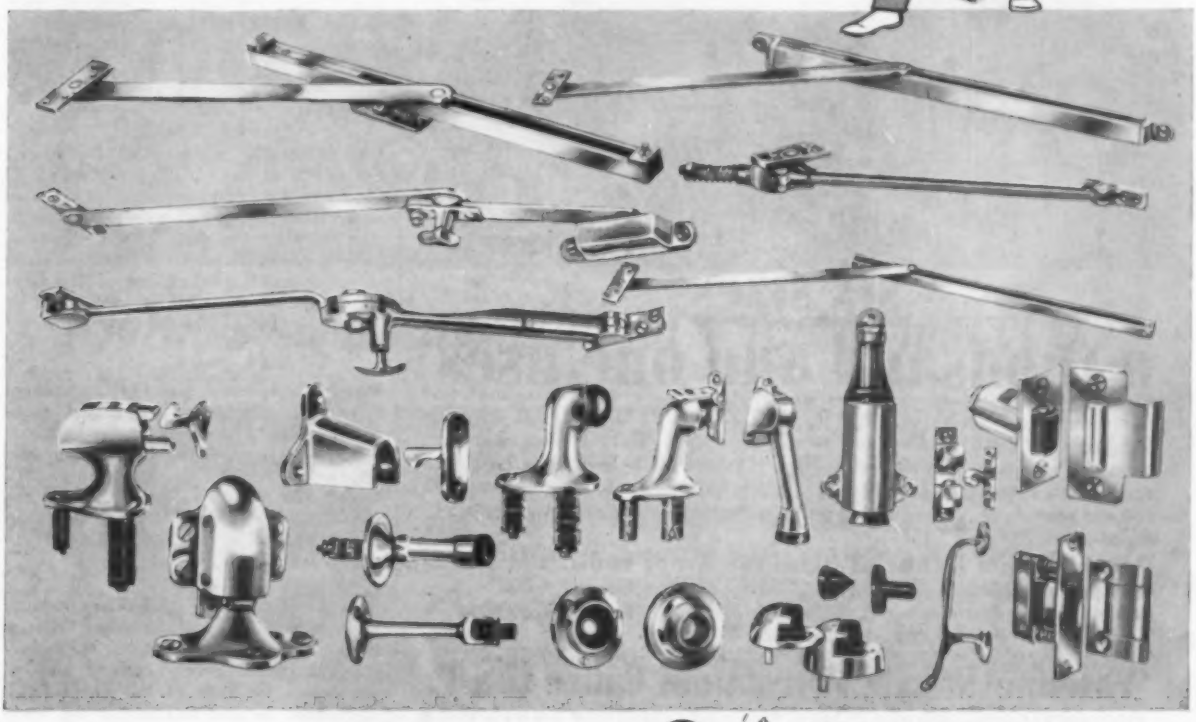


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For additional information, use postcard facing back cover.

• The new series of **Visi-Shelf units** designed to solve every filing problem, as described in a new catalog available from Visi-Shelf File, Inc., 105 Chambers St., New York 7. Data discuss how the various units provide 96 different styles and filing combinations.

For more details circle #238 on mailing card.

• A complete illustrated description of the full line of recessed troffers manufactured by Smoot-Holman Co., 321 N. Eucalyptus Ave., Inglewood, Calif., is presented in the new 36-page catalog, **"Your Guide to the Latest in Recessed Lighting."** Completely detailed mounting information and coefficients of utilization and photometric data for each fixture are included.

For more details circle #239 on mailing card.

• A 16-page, fully illustrated manual of **Static Conductive Linoleum Technical Data** is now available from Congoleum-Nairn Inc., 195 Belgrove Drive, Kearny, N.J. Uses, specification and installation data, cost information and testing and maintenance procedures on the floor covering, and the hazards of static electricity, are discussed.

For more details circle #240 on mailing card.

• **"Taste Tempting Recipes — for good menu planning"** are presented by the Processed Apples Institute, Inc., 30 E. 40th St., New York 16, ready to mount on five by eight-inch cards. Sixteen new recipes using canned apple sauce, apple slices and apple juice are included, designed for institutional food service.

For more details circle #241 on mailing card.



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a thousand and one uses

The wide range of sizes of 'VASELINE' STERILE PETROLATUM GAUZE U.S.P. gives it a thousand and one uses in the hospital and the office treatment room. As a pressure dressing in surgery . . . an occlusive dressing in burns . . . an emollient dressing on dry and nonacute skin lesions . . . a packing in nose, eye, and ear procedures . . . here is a dressing convenient to use and of guaranteed, sealed-in sterility.

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Suppliers' News

Bally Case & Cooler, Inc., Bally, Pa., manufacturer of refrigerated display cases and walk-in coolers and freezers, announces completion of a new modern steel and concrete building designed to house two special manufacturing operations: the construction of sealed multiglass units used in the display cases where complete air conditioning, with low humidity and high air filtering are essential; and a new Detrex degreasing system, for processing the steel frames of all display cases preparatory to finishing with rust-resistant coatings. The fireproof building is constructed under the latest concepts in industrial building design.

Cenco Instruments Corp., Chicago, announces the acquisition of **Mills Hospital Supply Corp., 6626 N. Western Ave., Chicago 45,** manufacturer and distributor of hospital and surgical supplies, with manufacturing plants in Chicago and Danville, Ill. and a distribution center in Houston, Tex. Cenco, according to the announcement, will operate the company as a subsidiary and Irving Mills, President, and his management will be continued. By adding Mills to Cenco's distribution centers, Mills products will be available to hospitals from coast to coast, and the Cenco Instruments line will be available to hospital research laboratories.

Continental Coffee Co., 2550 N. Clybourn, Chicago 14, distributor of coffee and allied food products to institutions, announces a merger with **Gold Prize Coffee Co., Chicago.**

Ives Cameron Co., pharmaceutical division of **American Home Products Corp.,** announces removal of its executive offices from 260 Madison Ave. to new and larger quarters at **685 Third Ave., New York 17.**

Ohio Chemical & Surgical Equipment Co., Div. of Air Reduction Co., Inc., Madison, Wis., producer of medical gases and related hospital equipment for use in anesthesia, oxygen therapy and resuscitation, announces acquisition by purchase of the complete product line of **The Gordon Armstrong Co., Inc.,** manufacturer of **Armstrong Incubators** for premature infants.

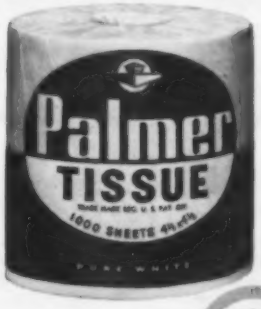
Puritan Compressed Gas Corp., manufacturer and distributor of medical gases and gas-administering apparatus to hospitals and the medical profession, announces removal of its home offices from **2012 Grand Ave., Kansas City 8, Mo.,** to the new **Puritan Building at Oak and Thirteenth Streets** in the **Kansas City downtown Civic Plaza Center.**

Scientific Equipment Mfg. Corp., manufacturer of sterilizers and other "Safety-Engineered" scientific products, announces removal of its general offices and all production facilities of the Jet Injector Apparatus, to new facilities at **20 North Ave., Larchmont, N.Y.,** a second company plant to provide additional space for its growing business.



These are the hands of a maintenance man who is responsible for washroom sanitary supplies. The selection of a Fort Howard tissue product in industrial washrooms is typical of efficient management. Fort Howard is a major supplier to leading industries throughout the country.

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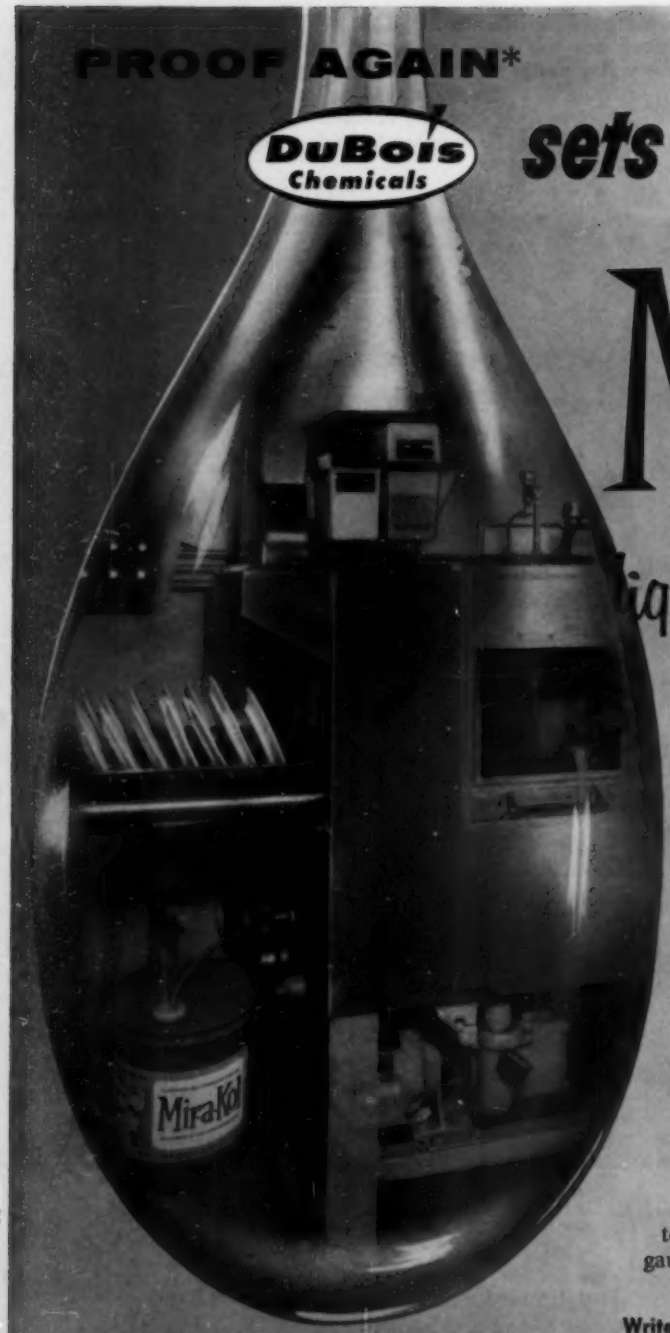
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After years of exhaustive laboratory and field testing, DuBois delivers a new miracle of *neatness*, *convenience* and *control* for your dish room — a new concept in dishwashing chemistry and efficiency—Mir-A-Kol, the super-active liquid.

Mir-A-Kol gives top efficiency and reduces labor costs with completely automatic injection directly from the shipping container. Metered at low concentration through DuBois' Viz-a-trol Dispenser into the wash section, Mir-A-Kol promotes new cleaning power, extra soil lifting action, greater grease emulsifying and superior rinsing for sparkling and mirror-like tableware. You'll like Mir-A-Kol's cost control — no manual handling, or loss through spillage or pilferage risk. No risk of misuse. Inventory control is maintained through a float gauge in the container.

Write today to Dept. M, DuBois Chemicals, Inc., Cincinnati 2, for more data on the modern miracle of dishwashing efficiency, Mir-A-Kol.

DuBois Chemicals



**Recently DuBois was first with a hard water rinse additive, Du-Dri, for automatic spot-free tableware drying—keeps rinse arms clean and final rinse section free of lime scale where it strikes.*

DuBOIS CHEMICALS, INC., CINCINNATI, OHIO

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USE THIS PAGE TO REQUEST PRODUCT INFORMATION

The index on this and the following page lists advertisements in this magazine alphabetically by manufacturer. For additional information about any product or service advertised, circle the manufacturer's key number on the detachable postcard and mail it. No postage is required.

Products described in the "What's New" pages of this magazine also have key numbers which appear in each instance following the description of the item. For more information about these items, circle the appropriate numbers on the postcard and mail it, without postage, to The Modern Hospital.

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I am interested in the items circled— **September, 1961**

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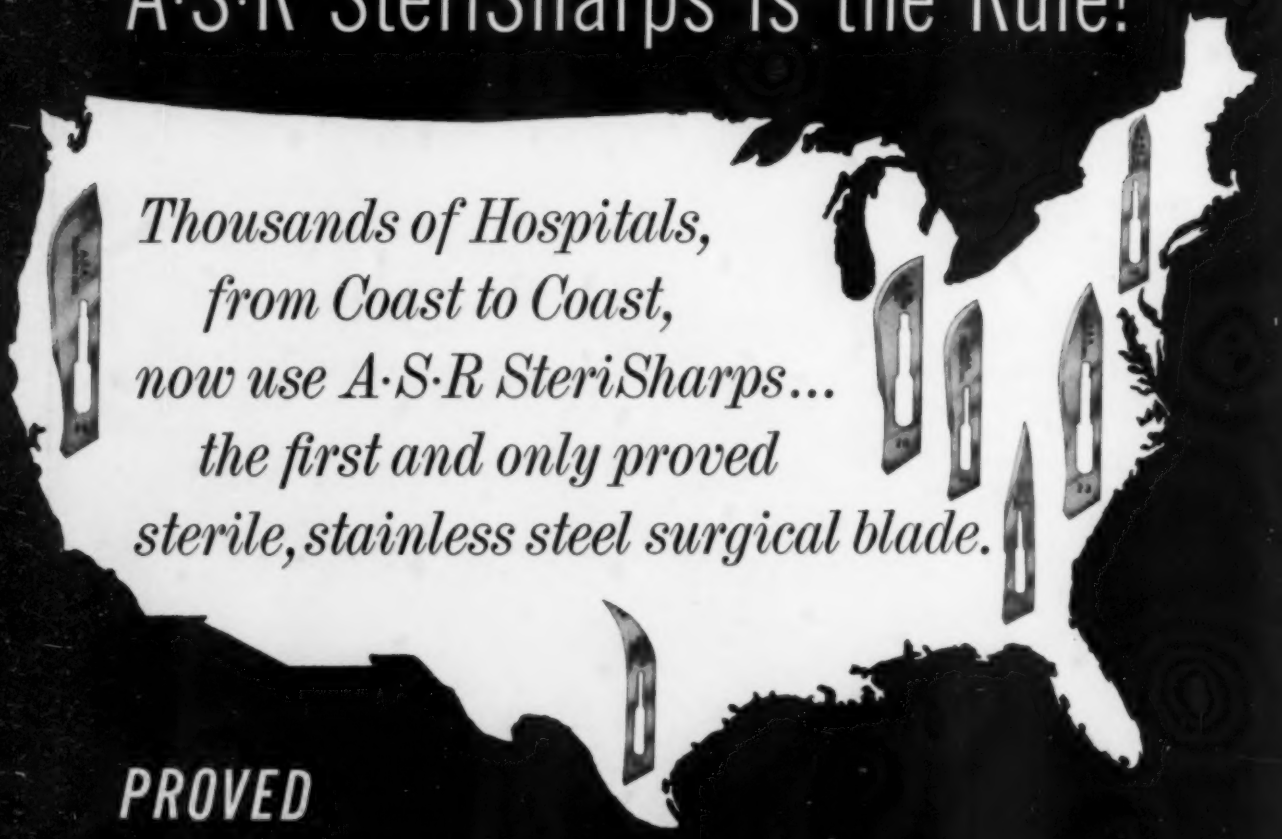
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